Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ vent Month 3 anuar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ursing N tonu timore 6. Sex If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) Year **Funeral** Birthplace (State or Foreign Country) 1 M 2 N Months Days Hours Min. Month, Day, Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Hmal 1 Nes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral items 23a 21218 permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene Hypiene Important: if item 27 is marked other than "natural", or items any injury or other traumatic event the Madical Fundamental Programments of the Madical Fundamental Programment of the Madical Fundamental Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 \square Never Married 2 \square Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes. Give 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) econday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Mathe xande 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9 4 Donation 5 Other (Specify) Hamily 21. Signature of Funeral Service Licensee 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death wsician/ DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of: signed by the attending physician and a betached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably ATHEROSCLESTIC Cordiovasular Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy performed' Yes 2 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to predical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Man of Death filled in by the funeral 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fune. Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MP 10059052 3 of person who completed cause of death (Item 23a) (Type, Print) 21211) a luje 100 St 31. Date filed (Month, Day, Year) State 0 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 022011 1:15 P. January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Winter Growth-Howard Center Columbia Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 07, 1 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 Ū Director Yrs. 214-12-2365 91 1919 Usual Residence of Decedent or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard **Elkridge** 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6213 Gatepost Way 21075 Jnited States o<u>f Amer</u>ica 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Horan Cecelia Kwiatkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Waugh (Daughter) 6213 Gatepost Way, Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2x ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Inc 01/04/11 Glen Burnie, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Miller-Dipple Funeral Home, Inc Mouso 6415 Belair Road, Baltimore, Maryland 21206 Pirt 1. Enter the disease, of emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Retween Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) (or as a con quence of) Examiner ununosos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sh 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: Certificate: To 1 Tes ASST LIVING 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Suicide Director; Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. air fifying Nurse Precitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the Signature and title of certifier 21090 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN 70 32. registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0003 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1,2011 Physician/ 9:45 A January Baker Thomas Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore <u>Greater Baltimore Medical Cente</u> Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) (Month Social Security Number Day, Year) 3. 1925 Maryland **Funeral** Days Hours 1 🕅 M 2 🗆 F 85 212-20-6413 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. 10a. State th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medir al Examiner must be notified at Completed by Funeral Director 1 🗆 Yes 2 🛛 No Timonium Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21093 113 Galewood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces? 1 Never Married 2 Married 2 🗌 No 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give White 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government 5+ FBI Agent 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ဂ္ Celeste Kelly Margaret Baker Felix Kavanaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Maryland</u> 113 Galewood Road, Timonium, Dorothy C.G. Baker/Wife or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1/8/11 permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🕅 Burial 2 🗌 Cremation 3 🗎 Removal from State Timonium, Maryland Dulaney Valley Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signande of Funeral Service Licenses

Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Final uwnm Physician/ Aspiration disease or condition resulting in death) Medical Due to (or as a consequence of): menon Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury unknown use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No cate has been signed by the atte page 2 should be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Parlansonis muasi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/ No Inpatient 2 ER/Outpatient 3 DOA 1 Tes မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27, Manner of Death Certificate: 1 Natural (Month, Day, Year) 5 Pending ☐ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 4 Homicide determined 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01 D0060242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Street (PTO) 32. Registrar's signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rooseve	elt Brock		on, Jr State of Ma I-For State Registrar	iryland / Dep Ce	partment of ertificate or		Mental H	_	201	1 00004	
	Physici	an/	Decedent's Name (First, Middle,Last)					2. Date of Deat	h	3. Time of Death	
Medica	l Exami	ner	Roosevelt Brockington					Month January 1,		1033 hrs	
			4a. Facility Name (if not institution, give street a Suburban Hospital boiler room	nd number)		4b. City, Town, or L Bethesda	ocation of Death		4c. County of D Montgome		
	uneral		5. Social Security Number 6. Sex	7. Age (In vrs	. last birthday)	If Under 1 Year	If Under 24Hrs	8. Date of Bir	th(MM/DD/YYYY) 9	•	
	irector		213-08-9714 1XM 2			Months Days	Hours Min.	9	/1970 Fo	oreign Country) DC	
			Usual Residence of Decedent	F 40	Yrs			07/12	71370		
	any		10a. State 10b. County	10c. Cit	y, Town or Locat	ion		*		10d. Inside City Limits	
7	show	5	MD Calvert	Lu	sby					1 X Yes 2 No	
j	28a-f show	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What (Country?	
-	yo will nous also usan will use mayanu iygise than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once										
	pms 2	Funeral		s Decedent Ever in ned Forces?		is Decedent of Hisp es, specify Cuban,			- 14. Race - Al White, et	merican Indian, Black, c.	
	orit	Fu	1	Yes 2 X No		X.				31ack	
4	ural",	ò	3 Widowed 4 X Divorced If Yes, Gior Dates: 15. Decedent's Education (Specify only highes		16a Deceder	Yes 2 No	specify: on (Give kind of v	ork done	Specify: 1		
-	Era t	ted		ege (1-4 or 5+)		ost of working life. I			l and a page of the same of th	,	
336	than (edica	Completed	2		Engine	eer			Suburban	Hospital	
2	Hygiene. Hygiene. Jother than "natur the Medical Exam	ខ	17. Father's Name (First, Middle, Last)						Maiden Surname)		
21215-0036	Mental H marked c event, t	æ	Roosevelt Brockingto				Mary Pow				
0.2	5 5 2 5	욘	19a. Informant's Name/Relationship (Type, Prin						ber, City or Town, S		
≥ 5	pennit. Department of Health and N Important: If item 27 is n injury or other traumatic		Mary P. Brockington/m 20a Method of Disposition	otner 120b		laygreen A		Date	leights,MI		
Baltimore,	of H	- 3	1 Burial 2 Cremation 3 Remo	val from State	crematory or oth		01/6	8/2011	Suitland	I MT	
E E	rtant rtant	- 3	4 Donation 5 Other Specify: 21. Ignature of Funeral Servic Censee			L1 Cemete			farch Fune		
Ba	Departir Import		ant C. holeron						on, DC 200		
Phy	/sician		23a, Part I. Enter the disease, or complications	that caused the deat						Approximate Interval	
- 400	aminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple	Sharp Force	njuries					Between Onset and Death	
EX	ammer			r as a consequence	of):						
		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (o	r as a consequence	of):					-11	
		를	cause. Enter Underlying Cause (Disease or injury that initiated		,-						
7	nsit	Exa	events resulting in death) Last Due to (o	r as a consequence	of):						
	oe executed sician and ourial - transi	dical Examiner	UNPENDED d AMENI	 DED							
G 3				yes, outcome of pre	egnancy				23d. Date of deli	verv	
6876(ing ph as the	2	2h Mes decedest programt in the	Live birth		tal death 3	Ectopic pregna	ncy	Month	Day Year	
Box (eaut ceruiteate e attending phys for use as the b	Sici	4 No. 2 No.	Pregnant at time of d Unknown	death 5 Ot	her (Specify)			0		
m -	by the	Physician/M	Part II. Other significant conditions contribu		resulting in the u	Inderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?	
of Vital Records, P.O. Box 68760	signed by	ব্র		•	ŭ	, , ,		1 Yes	2 No 3 1	Probably 4 Unknown	
ds,	s been si should b	Completed						24a. Was a		autopsy findings available	
Ö	ine taw icate has b page 2 sh	直			-			autop	med? deati		
8			25. Was case referred to medical			26.Place o	of Death (Check of	1 Yes 2	2 No 1 🗸	Yes 2 No	
of Vital	this certifi director,	o Be	examiner? 1 ✓ Yes 2 No	Inpatient 2	ER/Outpatient		Mana -		Residence 6 🗸 0	ther: Scene	
o d	After the	-1	27. Manner of Death 28a.	Date of Injury	28b. Time of I	njury 28c. Injury		28d. Describe h Subject stab	now injury occurred		
<u></u>	eath.	흝	S Periding	Month, Day,Year) UND: 11, 2011	FOUND: 1027 hrs	1 ✓ Ye	es 2 No	Subject stab	ibeu		
Division	ours after death cral Director: filled in by the	Certification:	3 Suicide 6 Could not be 28e.	Place of Injury - At		et, factory, office bui	ilding, etc.	28f. Location (S or Town, St		Rural Route Number, City	
	hours after	9	00- 0-+i5	ecify) Other (sp				Suburban Hos	pitál boiler room,	-	
	within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the b								
	To t	Medical		ner stated.	10/7	29c. License		-,,	29d, Date signed (
			1 to 6/1/26	Mark!	786	O.C.M			January 2, 20		
		,	30. Name and address of person who completed	cause of death (Ite	m 23a)						
V				Medical Exam		/. Baltimore Str	reet, Baltimo	re, MD 2122	3		
	Segis		31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture /	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2011 9:50 Α January William E. Baus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Linthicum Tate House Date of Birth (Month, Day, Year) 6/29/23 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 18 M 2□ F 87 Director 213-20-7817 Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 'natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Linthicum 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 817 Camp Meade Road 21090 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1948-52 1 ☐ Yes 2 ☑ No <u>≽</u> 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Curtis Engine Driver 10 other **Baltimore**, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (h and Mental h William Alfred Baus Anna Mae Bonner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Annapolis, Maryland Neice 865 Coachway Sandra Kraus 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 tof. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or once. Loudon Park Cemetery 1/6/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter n e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard refailure. List only one cause on each line. Immediate Cause (Final Physician METASTATI ON disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off Physician/Medical Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 □No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death or Attending 1 Natural 2 Accident 5 Pending investigation 1 🗆 Yes 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

the Hospital within 24 hor To the Fune completely f

> State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STAGNES

29b. Signature and title of certifier

OLE



900 CATON AVE BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **FRANCES** ELIZABETH BROWN 12:17P M 2011 Medical Tanuar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 WF Hours couply land 11/23/1921 Director 214-12-9885 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 🗌 Yes 2 💢 No Maryland Baltimore Towson 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a 102 Kenilworth Park Drive #2B 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meu gones. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |Robert Charles Brown Agnes Anastasia Forestell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Claire Goff 1 Lakecrest Court Towson, Maryland 21286 Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 01/06/2011 Baltimore, Maryland Donation 5 Other (Specify) nature of FuneralS ice Lice 22. Name and Address of Fact Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause on each line. Immediate Cause (Final ęhysician/ disease or condition resulting in death) Medical Due to or as a consequence of: Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury Exam that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ę Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ğ Hospital or Attending Physician: The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify, မ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HERESA BENICEWICZ Day 4 Physician/ -Month 1:00 PM anua 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital Baltimore Harbor If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 💆 88 Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MORP 1 PYes 2 No 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Be Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME MAKER OMR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 200x 8 701/ BAltimore, MARYLAND 4 Donation 5 Other (Specify) 5/145 ChejNA CKI FUNERAL HOMES 22. Name and Address of Facility
W. Dakke WSK. C. 21. Signature of Fur eral Service Lig 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Stroke with hemorrhapic translesses or condition with hemorrhagic transformation Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence on, Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completed filled i Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) RES 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South Hanover St., Baltimore, Maryland 21225

State Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

Zarrabi

31. Date filed (Month, Day, Year)

GUMAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per th g911 1-5-11 vt
State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ Brown, 2: 30P M 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Gildnrist Hospice Baltimore DWSON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Hours 212.94.958 1 M 2 - F (Month, Day, Year) MD **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director MD Ellicott toward 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21042 Funeral USA 744 Weatherstone Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+)
5+ Years Elementary/Seconday (0-12) Pearson Education rechnologi 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Robert Brown IJn Miller Cornelia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 19a, Informant's Name/Relationship (Type, Print) 24 2744 Weatherstone Drive Elicott City MD 1 and 2 s f Health item 27 Yolanda A. Bown/Wite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State Elkridge, MD 2011 Meadowridge Memorial Ol 07 4 ☐ Donation 5 ☐ Other (Specify) Vaugher C. Greene Fineral services 21. Signature of Funeral Service Licensee 2 Name and Address of Facility Randanstown ND 21133 Road Libert11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) metastatic Savcomh 1200 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nimonam embali 1 ☐ Yes 2 🐪 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has b page 2 sh Hospital or Attending Physician; The law autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 You Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify) Hospic & Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Coertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00070636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105 Baltimore, MD 21204 charles ST Sute Puta 701 N eura 32 Registrar's Signature State JAN O 5 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle, Laet) 2, Date of Death Physician/ ani Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ltimore 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth If Unde **Funeral** (Mpnth, Day Months Hours 1 M 2 D F Q Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use <u>ret</u>ired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LWite 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses unek 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER -UNG €nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ending physician are use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) ò Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy certificate has death? 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month, Day, Year, 12907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EYTAW ST #305 BALTIMENE MD 2/20 NANDA SHNAN, MD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TIMOTHY BUTLER Physician/ 7:00 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2349 LOT 38 Carroll HAMPSTEAL FAIRMOUNT KUAD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 X M 2 | F MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Hampstead Carroll MD 1 Yes 🔀 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Fairmount Road Trailer USÀ 21074 2439 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4x Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenence Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Virginia Bridges Armand Butler Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3170 Tillery Drive, Deltona, FL 32738 Justin M. Butler 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Journey crem. 1/5/2011 Final Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall

22. Name and Address of Facility

Maryland Cremation Services

PO Box 1413, Baltimore, MD 2

23a. Part 1. Enter the fileses, or completed in short of the popular part of the light of the popular part of the part of the light of the lig Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical consequence of: Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last ROS Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month 1 ☐ Yes 2 ☐ Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. typertipidamia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗶 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? injury **Natural** 5 Pending 2 🗆 No 2 Accident
3 Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29c License numbe 1009710 air State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Theresa Bisceglio Prudence Physician/ 3 1:30 рм January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 099-30-6711 1 □ M 2 🕱 F Months Hours 71971938 72 **Director** Usual Residence of Decedent r 28a-f show notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Germantown MD Montgomery 1 Yes 2 X No "natural", or items 23a or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20874 17805 Cricket Hill Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 9 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 21215-0036 White 1 ☐ Yes 2X No Specify. Specify: Completed 3 Widowed 4 X Divorced Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mortgage Underwiter Banking 12 marked other Be timore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nuzzeli Carmela Louis Ludiwigo Tutone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Isabella T. Bisceglio /Daughter 17805 Cricket Hill Dr., Germantown, MD 20874 per it. Page 1 and 2.8
Decartment of Health
Important: If item 27
any injury or other tr
one. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crem. 1 Burial 2 X Cremation 3 Removal from State 1/6/2011 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Euneral Service Licensee Dopota Marshall Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiac disease or condition onary Medical resulting in death) Examiner schem Sequentially list conditions, if any, seeding to him reclate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a nonsequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached f 1 ☐ Yes ∠ = 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Hospital: 1 🗌 Yes 2 🗹 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after deatl Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) M. D 2011 D0065505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20550 aiutan 9901 medical MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009 **ORIGINAL**

State Registra

0

3 13

3

7

M

ealio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 7:30 PMM January **Baugher** Medical Wesley James 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest Village 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number Sex 1X M 2 □ F 9. Birthplace (State or Foreign Funeral Months Days Hours 1073171908 Maryland Director 102 215-32-0935 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo 23a or 28a-f Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 8800 Walther Boulevard Apt # 1007 21234 S. A. or items hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 Yes 2 XNo Specify I Hygiene. other than "natural", Completed 3 X Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Tool and Die Maker Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or should be Edith Wood Edgar Baugher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a Department of Health a Important: If item 27 is any injury or other trains Essex, Maryland 21221 615 Rockaway Beach Avenue David Baugher Baltimore. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 2011 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line shock, or heart failure. List only one cause Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iii jiuy that initiated events resulting in death) Last Examiner Due to (or as a consequence of): s the burial-transit attending physician and Due to (or as a consequence of) Physician/Medical that the death certificate be 09289 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death signed by the attendin d be detached for use 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by the Hospital or Attending Physician: The law requires Division of Vital Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No filled in by the funeral director, page this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital 4 Nursing Home 5 Residence 6 Other (Specify) ျု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 102 Natural 5 Pending work? 1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [

within 24 hours after death. To the Funeral Director: After Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIN walth 8000 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 03 Registrar DHMH 17 Rev 7/2009 ORIGINAL

7.30 Pm

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OHN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIBEL,

32. Registrar's Signature

m)

ORIGINAL

D26358

RINCE FREDERICK, M. - 20678

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:29 201 january /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth 07-28-1953 Birthplace (State or Foreign Country)
 MD . Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 57 213-64-1744 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any jilivy or other traumatic event, the Medical Examiner must be notified of once. 10d. Inside City Limits 10a, State 10c. City. Town or Location 1 ☐ Yes 2 X No Director Harford MD Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 645 Carleton Trail 21014 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Staff Officer NSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Thomas Hardin Sr Gladys Louise Pear မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bel Air, Gerard Cox (husband) 645 Carleton Trail MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 01-08-2011 4 ☐ Donation 5 ☐ Other (Specify) St. Ignatius Cem. Forest Hill, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licencee Inc 610 W. MacPhail Rd BelAir, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 01 disease or condition resulting in death) /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician and as the bunal-transit Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check onl one 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA မ this 27. Manger of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident After Pending investigation (Month, Day Year) Injury 1 🗌 Yes 2 🗍 No Director; Af d in by the fu Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certifier E9-00 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ado 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN O

6

11-00030 Please	Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 201	1 00015
Santiago Antonio Lemus Colindres	State of Maryland / Department of Health and Mental Hygiene	00013
1- For State	Certificate of Death	

		I- For State Registrar		Ce	rtificate o	f Death		R	eg. No.	
Physicia Medical Examin	n/	Decedent's Name (First, Mid.		ACO ANTO	ONTO IF	MUS COLI	IDDEC	2. Date of Dea Month January 1	th Day Year	3. Time of Death 0948 hrs
		4c. County of D	Death							
		Washington Adventis	Montgome	•						
Funeral Director		5. Social Security Number NONE	6. Sex	7. Age (In yrs.	last birthday) 42 Yrs	Months Days		in. Octobe	th(MM/DD/YYYY) 9 c 4, 1968	0. Birthplace (State or oreign Country)E1 Salva
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	/	10c. City	, Town or Locat	ion				10d. Inside City Limits
*	5	MD Princ	e George's	в Нуа	attsvil	le				1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number	#201			10f. Zip Code		1	Og. Citizen of What	,
with th		8213 14th ST,	12. Was De	cedent Ever in U		20783 as Decedent of His	panic Origin? (merican Indian, Black,
	by Funeral	Never Married 2 1 3 Widowed 4 D	Married Armed F 1 Yes ivorced If Yes, Give Yes or Dates:	2 ^X No		es, specify Cubar			White, e	
, MD 21215-0036 and 2 should be filed within 72 hours after lealth and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner.	eted k	 Decedent's Education (Sp Elementary/Secondary (0-12 				nt's Usual Occupat ost of working life			16b. Kind of Busin	ess/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical	ם	6"		,	Cons	truction		_		ction, CO.
filed of the	S	17. Father's Name (First, Middle		o Colino	drog			ne (First, Middle, I Clinda Le	Maiden Surname)	
212 uld be Ments mark	To Be	19a. Informant's Name/Relation				111			nber, City or Town, S	State, Zip Code)
MD dd 2 shot and an 27 is 1	7	Osmin Antonio	Lemus Col:			l4th #301				, , ,
ore, land of Heal of Heal	ı	20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal fr		Place of Dispos crematory or ot	sition (Name of cer her place)	netery,	Date	20c. Location - Ci	ty or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: Wite	-	4 Donation 5 Other	Specify:		hetery (./13/11		ria, LaFronte
Bal permi Depar Impo	1	21. Signature of Funeral & ryio	e Licensee	hit	-				gton, DC 2	es Latinos, 1 20011
Physician /Medical	7	23a. Part I. Enter the disease, of failure. List only one caus	or complications that of	aused the death	n. Do not enter t	he mode of dying,	such as cardiad	or respiratory arr	est, shock, or heart	Approximate Interva Between Onset and
Examiner		Immediate Cause (Final diseas or condition resulting in death)		Injury consequence		ating Al	cohol I	ntoxicat	ion	Death
	ا	Sequentially list conditions,	b	·	·					
	Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	9 C	a consequence of						
cuted		events resulting in death) Last	Due to (or as a	a consequence (of):					
760, icate be executed physician and the burial - transi	/Medical	X UNPENDED				per me g	12 2-9-	11 vt	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5.7 c. (5.)
		IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live t	outcome of pregonth out at time of de	2 Fe	etal death 3 (Ectopic preg	nancy	23d. Date of de Month	livery Day Year
J. Boy t the deat by the att	Physiciar	Part II. Other significant cond	nknown 9 Unkn	7			i i- B I	Loop Didd		te to the cause of death?
of Vital Records, P.O. ng Physician: The law requires that the the tries certificate has been signed by uneral director, page 2 should be detact	歪	Tare in Outor organization	idente contributing t	o death but not	resulting in the t	andenying cause g	iveitii Patti.			Probably 4 Unknown
ords,	Completed							24a, Was		re autopsy findings available r to completion of cause of
Reco The law cate has	ĕ							perfo 1 ✓ Yes	rmed? dea	
tal Rec	a	25. Was case referred to medic examiner?	Illocoitely				of Death (Chec			
n of Vil ing Physic After this funeral dire	의	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatient		y at Work?		Residence 6 (Other:
OD Conding	틶	1 Natural 5 Per	(Month	n, Day,Year) -11-11	fd 9:00	10)	es 2 X No		le fall	
Division pital or Attendi ours after death eral Director: /	Certification:	3 Suicide 6 Co	uld not be 28e. Place	e of Injury - At h	nome, farm, stre	et, factory, office b	uilding, etc.			or Rural Route Number, City 5th Ave.
		29a Certifier	ermined (Specify) Physician: To the be		ent apa		ate and place, a			
To the Howithin 24 F	Medical		aminer:On the basis and manner s	of examination a stated	and/or investiga			at the time, date		
	2	29b Signature and title of certif		16		29c. Licens O.C.I			January 2, 20	(Month, Day, Year)
D 0	}	30. Name and address of perso	n who completed case	se of death (Iter	n 23a)					
ok of			puty Chief Medi	A-		Baltimore Stre	et, Baltimor	e, MD 21223		
Sta Registr		31. Date filed (Month, Adv Yo	6 2011	egistrar's Signat		Med				
DHMH 17 Rev 1/200	01	the the the			ORIGINA					DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death avanaus Physician/ Month 09:48 A M 201 alherine anuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🕅 F Hours 217-40-7513 66 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director MD Anne Arundel Pasadena 28a-f 1 ☐ Yes 2X No 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other there any injury or other traumest. Funeral 109 Riviera Dr. 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. White Specify: Completed 3 Widowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Gastrock Catherine Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shane Cavanaugh / Son 109 Riviera Dr., Pasadena, MD 21122 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State W. Arundel Crematory 01/06/2011 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ²² Name and Address of Facility Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Ph, sician/ etastatic denocarcinuma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or) -transit Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as JE FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1

Yes 2

No 3

Probably 4

Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🔀 No Other ည 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural Natural injury 5 Pending Accident work?
1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 45148 npleted cause of death (Item 23a) Type, Print)

Registrar DHMH 17 Rev 7/2009

State

of person who cor

6

LICARDO

00 d

Mountain

Maryland

asodena.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Day O2 ZOII Creek 1052 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita Harbor N/A Birthplace (State or Foreign Country)
 Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 1 - M 2/- F Director 1917 218-03-2725 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and the models. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Pumphrey N/A Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 210 Elizabeth Avenue 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify Black 3 🙀 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Henrietta P. Johnson Robert Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 243 Zeppelin Avenue Baltimore, Maryland 21225 Margie Creek 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/08/11 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Muocardial Medical resulting in death) r as a consequence of Examiner Vascular Disease Peripheral severe Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hypertension and as the burial-tran attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 Month Year 5 Other (specify) Day Pregnant at time of death 1 Yes 2 No the detached signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ ER/Outpatient 3 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending Natural work' 1 Tes 2 🗌 No Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 48898H 2011 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 3001 S. Hansver St. MD 21225 Gilbert 2.0. Harbor Hospital 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

11-00015 Davon Cruz

Physician/ Medical Examiner

> **Funeral** Director

> > or items 23a or 28a-f show

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene.

Physician /Medical

Żxaminer

Director 10e.

Funeral

To Be Completed

3 [۵ 15.

Examine

Physician/Medical

Completed

Certification: To Be

Medical

3

1 Part Ś

Pl	ease Typ	e or	Print in	n Blac	k inde	elible	ink. I	Ensur	e All C	opie	s Are Le	egible	9. 0 0 1	1 000
1- For State Registrar	St	ate of	f Maryla	ana / D	epartr <i>Certifi</i>	nent c	or Hea	aith an	d Ment	al Hy	giene	Reg. No.	201	000
Decedent's Nan	ne (First, Middl	e,Last)									2. Date of De	ath	V	3. Time of Death
Davon	Cruz										Month January	Day 1, 201	Year 1	0815 hrs
4a, Facility Name				mber)					Location of	Death			. County of Dea	
95 SB Nort	th of 212 Po	wdern	nill Road	_			Belt	sville					Prince Georg	
5. Social Security	Number	6. Sex		7. Age (In	yrs. last b	oirthday)	If Ur Mor	nder 1 Yea		_	8. Date of B	irth (MM.	Fore	irthplace (State or
151-70- Usual Residence		1 <u>X</u> M	2 F		30	Yr		iuis Day	s Hours	Min.	6/27/	198	30 c	ountry) NJ
10a. State	10b. County			10c.	. City, Tov	vn or Loca	tion							10d. Inside City Limi
Md.	Anne	Δr	undel	.	G1	en E	Rurn	ie						1 X Yes 2 1
10e. Street and Nu		711	unac.		- 41			ip Code				10g. Citi	zen of What Cou	untry?
16 G16	en Oak	La	ne				2	106	1		İ	US	SA	
11. Marital Status	011 0411		2. Was Dec		r in U.S.		as Dece	dent of His	spanic Origin		ecify Yes or N		14. Race - Ame	rican Indian, Black,
1 X Never Marr	ried 2 Ma	rried	Armed Fo	orces?	No	lf'	Yes, spe	cify Cubar	n, Mexican, I	Puerto F	Rican, etc.)		White, etc.	
3 Widowed	4 Dive		Yes, Give Year Dates:		, 40	1	Yes	2 X No	specify:				Specify: B]	lack
15. Decedent's E	ducation (Spec			ie complete	ed) 16a				tion (Give ki			16b. l	Kind of Business	
Elementary/Sec	condary (0-12)		College (1	-4 or 5+)		during r	nost of w	orking life	. DO NOT u	se retire	ed)			
			4			ΙT	Tec	h				I	MI	
17. Father's Name	(First, Middle,	Last)							18.Mother's	Name (First, Middle,	Maiden	Surname)	
Unkno	own								Carm	en	Jones	5		
19a. Informant's N		nip (Type	e, Print)		1	9b. Mailin	g Addre	ss (Stree	t and Numb	er or R	ıral Route Nu	mber, C	ity or Town, Stat	e, Zip Code)
Carmen	Jones		_							e,	Glen		nie, Mo	
20a. Method of Dis			1.50		20b. Place	e of Dispo			metery,		Date	20c.	Location - City o	r Town, State
1 X Burial 2		-	Removal fro		Ceda			•	-	17	/2011	Ra.	ltimore	bM c
4 Donation 5			· 1	- ()	Ceua	22.	Name an	d Address	of Facility	-/ • /	-	ра.	r c i moi e	e, mu.
ton	(all m	Ka	VI			1	308	P Eu	rothe taw F	rs lac	Funer ce,Bal	al Ltin	Servic nore,Mo	ce, PA d. 21217
23a. Part I. Enter t	the disease, or nly one cause	complica on each	atiòns that ca Iine.	aused the d	death. Do	not enter	the mode	of dying,	such as car	diac or	respiratory ar	rest, sho	ock, or heart	Approximate Interv Between Onset an
Immediate Cause	(Final disease		ultiple Inju	iries										Death
or condition result	ing in death)	Due	e to (or as e	conseque	quence of):									
Sequentially list co		b				-								_
if any, leading to in cause. Enter Und		Due	e to (or as a	conseque	nce or):									
(Disease or injury events resulting in		Due	e to (or as a	conseque	nce of):									1
		d												
UNPENDED)		MENDED				·							
IF FEMALE:			23c. If yes, o	outcome of	pregnanc	y						230	f. Date of deliver	ry
23b. Was decedent past 12 month		e	1 Live b			2 🗌 Fe	etal deati	h 3[Ectopic p	regnan	су		Month	Day Year
1 Yes 2	No 9 Unk	2011		ant at time	of death	5 🗌 O	ther (Sp	ecify)				- 1		
			9 Unkno								Tag Bill			
Part II. Other sign	incant conditi	ons co	entributing to	death but	not result	ing in the	underlyir	ng cause g	iven in Part	I.		_		the cause of death? bably 4 Unknown
										_	24a. Was	an		utopsy findings availab
-			-								eutop perfo	rmed?	prior to death?	completion of cause of
25. Was case refer	rred to medical						-	26 Place	of Death (C	heck or		N	0 1 Y Y	es 2 No
examiner?		Hosp	pital: 1 Ir	npatient :	2 EP#	Outpatient	3 🗆					Recido	nce 6 🗸 Othe	er Scene
1 Yes 27. Manner of Dea	2 No		28a. Date	<u> </u>		. Time of			y at Work?		8d. Describe			n. Justie
1 Natural	5 Pendi	ing	FOUND	Day, Year)	FO	UND:	gur y	1 .	es 2 ✓ N	l n				th utility pole

To the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours af er death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

25. W e 27. M 1 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 95 SB North of 212 Powdermill Road, Beltsville, MD determined (Specify) Major Road / Highway Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2

29b. Signat 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 2, 2011

me and address of person who completed cause of death (Item 23a)

OCME

Laron Locke MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State 0 6 2 Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ronald Lee Cator, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 216-50-4064 Mov . 24 , 1946 Hours Director Country) MD Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2602 Hamilton Ave. 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 No Specify: Specify:Black Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Teamship Trade Elementary/Seconday (0-12) College (1-4 or 5+) Assoc. Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Royster Lorraine Cator 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Cator (wife) 2602 Hamilton Ave. Balto, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Parkwood Cem....Jan.7,2011 Baltimore, MD grature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Mycardia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** leurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a co sequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day signed by the at Id be detached for Month 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No this certificate 2 1 No 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၣ 1 Yes 2 4 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number Name and address of person who d empleted cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

LOCH

540

eru66

31. Date filed (Month, Day, Year)

w

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louis Joseph Cavicchio, Jr. Month P M 2011 January Medical 7:11 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 10, . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Days Hours Min. Months Year) 83 Country **Director** Vrs 206-14-3800 Sept. Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2 X No MD Ellicott City Howard 10e Street and Number ō 10g. Citizen of What Country? Examiner must be Funeral with 23a 8270 Stone Crop Drive Unit M. 21043 USA items ; 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. ō þ 1 Never Married 2 Narried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: White "natural" Specify Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) than Procurement Operations & within 7 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Logistics Manager Westinghouse permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis Joseph Cavicchio, Sr. Margaret Ficca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Cavicchio Wife 8270 Stone Crop Drive Unit M: Ellicott City,MD 21043 Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 1/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Name and Address of Facili Sterling Ashton Schwah Witzke 21. Signal re of F peral Service Libense uneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsvill MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ antercation. disease or condition MUDORTH 180KS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a the for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy rate has been signed by the atter page 2 should be detached for u in the past 12 months? Month Pregnant at time of death Dav Vear 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed tipulotrandobetes discose, Othal 1 ☐ Yes 2 ☐ No 3 ☐ Probably ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2VX No certificate 1 🗌 Yes 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: ပ္ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signati

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day АМ Talbert Cox, Jr. 4:05 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Months Aug. 12, Year) 928 North Carolina Hours 82 Director Yrs 242-32-4205 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 🎇 No NC New Bern Craven 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 255 Sanders Lane 28562 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 2 No Specify. Specify: Black If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance City of New Bern Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ၉ Talbert Cox, Sr. Sudie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 255 Sanders Lane, New Bern, NC Cox (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Cox Family Cemetery 1-9-2011 4 Donation 5 Other (Specify) New Bern, NC 22. Name and Address of Facility
Oscar's Mortuary
1700 Oscar Dr... 21. Signature of Funeral Service Licensee New Bern 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir that the death certificate be executed attending physiciar Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ō Day Pregnant at time of death the detached 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Physician; The law requires Completed 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27 Manner of Death Certificate: 28b. Time of 28d, Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 \square Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1🜊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the best of my Knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Road, Clinton, MD Corp Pierson, MD

DHMH 17 Rev 7/2009

State Registrar Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death edent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 945AM 201 anuary /Medical Facility Name in not institution, give sireet and number) 4b. City, Town, or L 4c. County of Death Examiner hmorely N/A Social Security Number If Under 1 Year thday) 8. Date of Birth (Month, Day, April 3, 7. Age (In Vr. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗸 F Months Days Min 87 137-14-8228 Yrs. Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County show 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examinar must be notified Director Maryland N/A Fells Point 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 239 South Washington Street 21231 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 9 altimore, Maryland 21215-0036 1 ☐ Yes 2 INo If Yes, Give Year or Dates: Specify. þ Specify: White 3 Widowed 4 □ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Clerk marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it and 2 should be file Health and Mental H tem 27 Is marked oth Be John Fox Kathryn Lynch ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (O Jane Coutts-Ambrose (Daughter) 239 South Wahington Street, Baltimore, Maryland 21231 ortant; If Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8, 2011 Waynesmoor, Pennsylvania permit. Page Department o Important: If any Injury or Holy Sepulcher Cemetery January 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death erlate Cause (Final Physician Aspiration neumoni ease or condition resulting in death) ohours /Medical Due to (or as a consequence of) Examiner Multi ears Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 menths? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ned by the a 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ enosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 □Yes 1 ☐ Yes 2 **X**No 25. Waş çase referred to medical Be 26. Place of Death (Check only one) examiner? ¥ Yes 2 No Hospital: Other: 4 \(\sum \) Nursing Home Certification: To 1 Inpatient ER/Outpatient 3 DOA After this 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Colleen Christmas, Hopkins Boynew 5505 0 5 31. Date filed (Month, Year) State 2011 Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Henry Crispens, Jr. 2011 6:15 Рм January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Overlea Health & Rehabilitation Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year Jan. 9, 1 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months 87 Baltimore, 215-12-8493 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a Funeral 5685 Leiden Road 21206 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

Xyes 2 No WWII Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injuy or other traumatic event, the Medicial Exa 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Firefighter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mamie Herr William Henry Crispens, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 Creston Road, Dundalk, MD 21222 Richard Crispens/ Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Jamary 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State Forest Hill, MD 3, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 23a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mm diate Cause (Final Schouiz Onset and Death Physician/ Cano Medical resulting in death) Examiner miller reludur Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events as a consequence of) pleu in Exami the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? after death.

Director: After this certificate has a in by the funeral director, page 2 s autopsy Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital REHAIS 2 No ျှ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie Anca Fruiinoiu, MD D 70265 DOV who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN EN BLUT (Month, Day,

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 Year Charolette Regina 11:45P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death 1958 Sue Creek Drive Essex Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Davs Months Hours Min. 03776*/1*938 Marviand Director 219-26-7546 72 Yrs Usual Residence of Decedent 23a or 28a-f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland asstrained to Health and Mental Hygiene. Asstraint of Health and Mental Hygiene. oortant: If teem 27 is an arked other than "natural", or items 23a or 28a-f show oortant: If teem 27 is an arked other than "natural", or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Directo Baltimore Maryland Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1958 Sue Creek Drive 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Scheper Margret Guy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1958 Sue Creek Drive, Essex, Maryland 21221 Joseph Cook (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 01/07/2011 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility River all Home, P.A. 21. Signature of Funeral Service Lic 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onsel and Death Immediate Cause (Final Ph_sician/ -uns disease or condition re liting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No ☐ Yes 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Hospital 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier f death (Item 23a) (Type, Print) 30. Name and address of person who completed of Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 9:30 P M Physician/ William MacTaggart Cantler 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Harford Bel Air 324 Williams Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day, Ye 1<u>929</u> Funeral Pennsylvania Days Hours Months 1 X M 2 D F Yrs. 178-22-7538 Director Usual Residence of Decedent 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 ¥ Yes 2 □ No Harford Bel Air Maryland 10g. Citizen of What Country? 10f. Zip Code Funeral 324 Williams Street 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 6b. Kind of Business Industry Aircraft Parts 15 Decedent's Education (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturer Assistant Supervisor 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Janet Netta MacTaggart Raymond Walter Cantler permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 324 Williams Street, Bel Air, Maryland 21014 Helen Cantler / Spouse Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 5 Harford Memorial Gdn 1-7-11 Aberdeen, Maryland any Injury 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility McComas Funeral 1317 Cokesbury 21. Signature Funeral Service Licensee l Home, P.A. Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unc Physician/ Medical Due to (or as a gonsequence of): Examiner SCI amic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Be Completed by Physician/Medical The law requires that the death certificate be Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 1 L Yes 2 L g L Unknown been signed by the s g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? page 2 performed? Yes 2 N 1 Tyes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital the Hospital or Attending Physician: director, Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Yes 2 No After this 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death work?
1 Yes 2 No 1 Natural 5 Pending within 24 hours area control to the Funeral Director. After a the Funeral Director. M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce tifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 208 JOSEPH ANGEL 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00026 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 9:00 P M Physician/ Bonnie O. Counts 2011 Jan. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Cockeysville 800 Warren Rd. 8. Date of Birth (Month, Day, May 3 1 9. Birthplace (State or Foreign Country) VA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 🗆 M 2 86- 85 May Director 220-22-9625 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Cockeysville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21030 800 Warren Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 8 n/a Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Dixie Jane Hall Elihue H. Snow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DiCocco DiCoilo/daughter 210 Burning Tree Rd., Timonium, MD 21093 Cathy A. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/4/TT XBurial 2 Cremation 3 Removal from State Timonium, MD Dulaney Valley Memorial Gardens Donation 5 Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 of Funeral Service Lic Inc. 23a. Part 1. En rt le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cruse Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year cate has been signed by page 2 should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Μ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 39050 011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timonium Medical Ctr. 16 Greenmeadow Dr., G105, Timonium, MD 21093 Leonard Raucher, M.D. 31. Date filed (Month, Day, Year) agistrar's Signature State JAN 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20T1 1:25 Coburn P.M Maude Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Health & Rehab. Bel Air Harford If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Days Hours Min une9, I West Virginia Director 87 236-32**-**6383 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Md. Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 708 Mayton Court 21014 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Receptionist State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျဉ Edward Frankhouser Dora Thomas of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonya O. Varga/Daughter 708 Mayton Court Bel Air, Maryland 21014 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January permit. Page 1 Department of Important: If it any injury or o ó 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 5, 2011 Baltimore, Maryland Signature of Fune Service Censee 22. Name and Address of Facility Kaczorowski Funeral Rome, PA 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Hypertension Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Other: AND Nursing Home 5 DResidence 6 DOther (Specify) ြု 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide s after death Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Exami 🛪: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours a Funeral I within 24 hou

To the Fune

completed file

> State Registrar

Certifying Nd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

Day, Yea 2011

only on 29b. Signatu

DHMH 17 Rev 7/2009

ectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D 28339

29d. Date signed (Month, Day, Year)

January 2, 2011

29c, License number

Linda Freilich, M.D. 101 E. Wheel Road Bel Air, Maryland 21015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 7:18 Р м 2011 Patricia Dowdv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Forest Haven Nursing Home Catonsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 6. Sex **Funeral** 1 □ M 2🛣 Months Hours Min. May 26, Year 937 73 212-36-3907 Yrs Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Street Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 USA 3241 Ady Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event the Medical P Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Post Master Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas P. Leonard Marie Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Dowdy, Son 3241 Ady Road Street, Maryland 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 01/06/11 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final NO Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a d be detached f Unknown g 🔲 Unknown P.O. Part II. Other significant copditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has 1 Yes 2 No 1 Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of De-th (Check only one) Be examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manger of Death Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral Natura 5 Pending 1 Yes 2 No M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Charlene Doukas 10 :56P M Dieter Medical Januarv 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Harford Be1 Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) ec. 15, 1 ☐ M 2 🔽 F Days Hours Min Indiana **Director** 217-38-0628 1940 Usual Residence of Decedent 10a. State 10b. County ä 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1 ☐ Yes 2XXNo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 3419 Albantowne Way U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No 1 ☐ Yes 2 ☐ YNo Specify: Specify: Completed 3 Divorced 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry al Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygier 27 is marked other traumatic event, the Accountant Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Doukas **Gladys** Banning Augustus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trat once, 3419 Albantowne Way Charles Dieter/Husband Edgewood Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 01/05/2011 Timonium 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Miller-Dippel Funeral Home,
6415 Belair Road Baltimore 21206 incations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. Onset and Death Immediate Cause (Final / Physician disease or condition resulting in death) neumania Medical Due to (or as a consequence of) Examiner Septic Shoc Sequentially list conditions. Examine if any, leading to immediate cause. Enter on Jernying Cause (Disease or iinjury Due to (or as a consequence of) this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardiac arrest 1 ☐ Yes 2 SNo 3 ☐ Probably 4 ☐ Unknown Mellitus Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Acidosis 2 🗌 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ျှ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Hospital or Attending (Month, Day, Year) 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death pace and place, and due to the cause(s) and manner stated a Courthying Nurse Practioner: to the basis of examination and/or investigation, in my opinion, death pace and place, and due to the cause(s) and manner stated a Courthying Nurse Practioner: to the basis of examination and/or investigation, in my opinion, death pace and place, and due to the cause(s) and manner stated a Courthying Nurse Practioner: to the basis of examination and/or investigation, in my opinion, death pace and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0065421 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive, Bel Ar, Maryland 21014 Christa R. Fistier 500 Upper MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 06 2011 Registrar DHMH 17 Rev 7/2009

75

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 10 30 AM FAYE DYER ANNA JANUARY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Year) 12/14/1953 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 408-96-8807 <u>Tennessee</u> Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Maryland Charles Waldorf 1 **X**Xes 2 □ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 11479 Shearwater Drive 20601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XXIIo 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ∐ Yes 2 XXNo Specify. If Yes, Give Year or Dates à 3 Widowed 4 XX Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cassemco Inc. Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental h Clarence Andrew Cantrell Lola Mekil Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Carl Cantrell Brother 11479 Shearwater Drive Waldorf Maryland 20601 Method of Disposition

WM Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Jo. Department of Important: If any injury or once. Shipley Cemetery 01/08/2011 ☐ Donation 5 ☐ Qther (Specify) Cookeville, Tennessee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral 23a. Part 1. Enter the dise shock, or heart failu 6500 York Road Baltimore, Maryland 21212 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only Immediate Cause (Final **Physician** Neu propenic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myelord Cenkemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 No Hospital: 1 🔀 Inpatient Other: 4 \sum Nursing Home 3 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) 9 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending

Box 68760, P.O. | Division of Vital Records,

filled in by the within 24 hours a Hospital

KARTHIK 31. Date filed (Month, Day, Year) State JAN 0 6 2011

3 Suicide

29a. Certifier (check only

Medical

4 🗌 Homicide

29b. Signature and title of certifier

SURESH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

determined

6 Could not be

32. Registrar's Signature arke

Registrar DHMH 17 Rev 1/2001 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2 No

RES- 000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TAPRAAKY

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2^{Day} 2011^{Year} January 6:19 AMJohn Rocco Dash Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) an. 2, 2011 54. 1 M M 2 D F Maryland Yrs. Jan. **Director** None Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5925 Anniston Road 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Ira Dash Rachel Cayelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 5925 Anniston Road, Bethesda, Maryland 20817 Kenneth & Rachel Dash/Parents 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1

Burial 2

Cremation 3

Removal from State January Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Robert A. Fumphrey Funeral Home/Bethesda-Chevy 21. Signature of Funeral Service Licensee M00198 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5hr. 54mins. Physician/ Extreme Prematurity Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or impury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year sate has been signed by the a page 2 should be detached in g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 K N death? certificate 1 ☐ Yes 2 ☐ No in 24 hours after death.

he Funeral Director: After this certifical pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 🔁 Natural 5 Pending 2 Accident
3 Suicide 1 Tyes 2 🔲 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

Box 68760

P.O.

Division of Vital Records,

DHMH 17 Rev 7/2009

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hepful U

Theophil A. Stokes, M.D.

0 6 201

00067535

704 F Street, N.W. Washington, D.C. 20002

1/2/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ 4:10 January 1 Alice DeMartino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Gilchrist</u> Towson 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 💢 F Michigan Director 383-26-4382 Sept Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Towson Marvland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21286 U.S.A. 1403 Midmeadow Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. ģ 1 Never Married 2 X Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Divorced 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Own 12 <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Emilv Breske Bronislaw Baczewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 1403 Midmeadow Road Towson, Maryland Peter DeMartino Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-5-2011 ☐ Donation 5 X Other (Spettintombment Timonium <u>Memorial Gardens</u> Signature Wun val Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lymphocy disease or condition resulting in death) monic PROCES Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 XNo Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ partial small bowel obstruction 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed Certificate: To Be

Division of Vital Records, P.O. Box 68760

							24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
10	25. Was case referred to medical					26. Place of Death (Che	ck only one)		
	examiner? 1 Yes 2 No	Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatient	з 🗆	DOA Other: 4 Nursing I	lome 5 🗆 Residence 6	Other (Specify) HTSp1 (
	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	1	Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e.	Place of Injury - At he building, etc. (Specif	ome, farm, stree	et, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29b. Signature and title of certifier MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 29d, Date signed (Month, Day, Year) D0070435

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Part el N Charles Bultimore 6701 Suite 4105 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

JAN 05 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:54 Am Dowery Zo Year James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Byrnie Balto. WASH len MEDICAL GENTER AA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. (Month), Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-56-4418 48 MD **Director** 10/31/6 Usual Residence of Decedent 28a-f shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Baltimore 10e, Street and Number 10g. Citizen of What Country? Funeral 1230 2 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK If Yes, Give Year or Dates 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) TRUCK DRIVER GUEST SUPPLY DIST. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ISABELLA DUPPINS WILLIAM C. DOWERY, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is TERESA A. DOWERY/WIFE 2219 SIDNEY AVENUE, BALTIMORE, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Donation 5 Other (Specify) CROWNSVILLE VET CEM 01-10-2011 | CROWNSVILLE, MD 21. Sinnatur Fineral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F..H, INC BALTO. MD 21217 1701 LAURENS ST., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ robable disease or condition resulting in death) Dulmonary Medical Due to (or as a consequence of) Examiner arco 10/05/ Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequent Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Other (specify) been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0-36885 1/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 51 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 05 20 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _Month 2011 22:50 PM Physician/ Joe J. Dicarlo January 0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F Months Days Hours (Month, Day, 218-05-3/27 Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director ESSCX Examiner must be notified 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. o, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Tes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Homportant: If item 27 is meany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su 2 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number MATO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State -2011 4 Donation 5 Other (Specify) 21. Signatur Funeral Serpice Licensee NNINO 22. Name and Address of Facility 2/224 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory hours disease or condition Medical resulting in death) Examiner 12 hours pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetal dea: ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မူ 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th
completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Ycertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00067118 02, 2011 MP January 30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print) Westergaard Baltimore, 4940 Eastern Avenue 31. Date filed (Mont), Day Ye Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of Ma	aryland		ırtmen <i>tificat</i> e			Mental H			2 2 2 2 2
	_		Registrar 1. Decedent's Name	(First, Middle, L	ast)			incate	OIL	Jean	2. Date of D	Reg. N	2011	3. Time of Death
	Physicia		Alban		er						Month January		2011	10:05 A ^M
-	/Medic Examin				ve street and number)			4b. City,	Town, or	Location of Deatl			c. County of Death	
			8314 Old						hesd				Montgomer	-
	Funeral		5. Social Security Nu	ımber 6.	1X M 2 D E	e (In yrs. las	t birthday) . Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of E	Da <i>y</i> , Yea	r) Cou	place (State or Foreign ntry)
	Director		016-16-67 Usual Residence of		95						rebruar	y 13,	1915 Gern	nany
	yland how	,	10a. State	10b. County		10c. City, 7	Town or Loc	cation						10d. Inside City Limits
	e Ma	Director	Maryland	Montgom	ery	Beth	esda							1 ∐ Yes 2 X No
	vith th	Dire	10e. Street and Num					10f. Zip					Citizen of What Cou	•
	sath v	eral	8314 01d	Seven Lo	cks Road 12. Was Decedent B	Tune in LLC	10.11		817	iononio Ovinino (P	nacity Vac or N		ited Stat	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the alten 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the medical Examinar must be neithfact at or other traumatic event, the medical Examinar must be neithfact at	by Funeral	11. Marital Status 1 □ Never Marrie 3 🏿 Widowed	ed 2 Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give		1	Yes, spec		ispanic Origin? (S n, Mexican, Puert Specify:	o Rican, etc.)	4O-	14. Race - Ameri Black, White, Specify: Wh	
2-0	72 hou	ted	(Space	15. Decedent's E	ducation		16a. Deced	lent's Usua	l Occupa	ation	dina	16b.	Kind of Business/Ir	ndustry
7	within 7 iene. r than "r	Completed	Elementary/Secor		College (1-4or 5	+)			e retired	luring most of wor)	KING		dical/	
7	filed wi Hygier other th	Co	17 5 11 11 11	Time Add the Land	5+	I	Physic	cian		40.14-11-1-1-11-1	(Ci-4 Midd		n Practic	:e
anc	l be fi	Be	17. Father's Name (t)					18. Mother's Nan		е, маю	en Surname)	
Ĕ	should and Mer s marke umatic	우	19a. Informant's Na		(Type Print)		19h Mailin	n Address	(Street a			nher City	or Town, State, Zi	n Code)
S	nd 2 s alth ar 27 is r trau			•	Daughter			_					Maryland	
ē,	es 1 and 2 and Pealth a item 27 is		20a. Method of Disp	osition		20b. Plac	e of Dispos	sition (Nam	ne of	e) Innu	ary 4,	20c.	Location - City or T	own, State
<u>=</u>	Pages nent of I ant: If its ury or o			ACremation 3.5 5.☐Other (Spec	Removal from State	1	omery C			i	2011	Bet	hesda, Ma	aryland
Baltimore, Maryland 21215-0036	permit. Pages Department or Important: If i any injury or once.		21. Signature of Fur	neral Service Lice		01596	Rot 755	Name and pert A. 7 Wisc	Addres Pump onsir	s of Facility hrey Funer n Avenue, B	alHome/F ethesda,	Bethe Mary	sda-Chevy C yland 20814	hase, Inc.
			23a. Part 1. Enter th	e disease, or cor t failure. List only	nplications that caused one cause on each lin	the death.								Approximate Interval Between
	Physician		Immediate Cause (I	Final 1	_a Cardio	pulmor	nary a	arres	t					Onset and Death
	/Medical Examiner		resulting in death)	•	Due to (or as a									
		e.	Sequentially list con	ditions,	b. Aortic			- Sev	ere					
	uted d ansit	Examiner	Sequentially list con it any, reading to increase. Enter Under Cause (Disease or i that initiated events	lying njury										
oʻ	an an rial-tra	Еха	resulting in death) L	ast	Due to (or as a	a consequen	nce of):							
68760,	ificate be executed g physician and is the burial-transit	edical			d									
		Med	IF FEMALE:											
Box	The law requires that the death certific ate has been signed by the attending plage 2 should be detached for use as t	Physician/M	23b. Was decedent in the past 12 r		23c. If yes, outcome	2 Fetal de	eath 3	Ectopic pr		/		1.0	23d. Date of deliver Month	very Day Year
o i	that the de ned by the a detached f	ysic	1 □ Yes 2 □ 9 □ Unknown	No	4 ☐ Pregnant at 9 ☐ Unknown	time or dear	tn 5∟	Other (sp	ecity)					,
σ.	that ned by deta		Part II. Other signifi	cant conditions	contributing to death bu	ıt not resultir	ng in the un	derlying ca	use give	en in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
rds	w requires to be signeral should be a	ed by									1 🗆	Yes	2 X No 3□ Pro	bably 4 ☐ Unknown
ပ္ထ	law re as bea 2 sho	Completed									24a. Wa		24b. Were aut	opsy findings available
ř	The I	E									per	opsy formed? 2 X N	death?	ompletion of cause of
<u>≡</u> .	cian: ertific ector,	Be (25. Was case referre	ed to medical					4-3-3	26. Place of Dea				Tie.
5	physic this c		1 ☐ Yes 2 💢 1			nt 2 ER	<u>_</u>			4 Li Nursing H			6 ☐ Other (Spec	ify)
ב כ	After After funera	ion	27. Manner of Death 1 X Natural	5 Pending	28a. Date of Injur (Month, Day	ry <i>(, Year)</i> 28	3b. Time of Injury	M 28	Bc. Injury Work		28d. Describe	e how inj	ury occurred	
Division of Vital Records,	Attending Physician: r death. ector: After this certifice by the funeral director,	ficat	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not be	De 29e Place of Inju	ırv - At home	e, farm, stre			Yes 2□No	28f. Location	(Street:	and Number or Rur	al Route Number
<u> </u>	al or A after Direction by	Certification: To	4 Homicide	determined	building, etc	. (Specify)	,, one	.,,,			City or T			
:	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifler (Check only one)	1 X Certifying P 2 ☐ Medical Exa	hysician: To the best of mines: On the basis of and manner sta	examination	edge, death n and/or inv	occurred a	at the tin	ne, date and place pinion, death occu	e, and due to the	ne cause e, date a	o(s) and manner as and place, and due	stated. to the cause(s)
	Vithin To the compl	Me	29b. Signature and t	itle of certifier			>	29c.	. License	number		29d. E	Date signed (Month,	Day, Year)
	, ,		•	1	7			D	0053	3711		Jan	uary 4, 2	2011
2	5+1		30. Name and addre	ess of person who	completed cause of de	eath (Item 23	 3a) (Type, F	Print)						
7	/ /		Pasquale		M.D. 55	30 Wi:	scons	in Av	enue	#1400 ,	Chevy	Cha	se, MD 20)815
	Stat	te	31. Date filed (Monti	h, Day, Year)	32. Registra	ar's Signature	la V	i						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1%a Per FH G911 1/07/2011 JH. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lora Ellis 8:30P M 2011 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Manor Care Towson 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 XF Months Days Hours Min. 80 223-36-8248 Director 1930 North Carolina April 22, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Madical Examination retified at Bel Air Maryland Harford 1 ☐ Yes 2 🛛 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21014 1320 Conovingo Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 127 is marked other than "1." r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 17. Father's Name (First_Middle_Last)

Dardle

Dardie Ellis 18. Mother's Name (First, Middle, Maiden Surname) Be Nora Brooks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Crabbe Court, Conowingo, Maryland 21918 Department of Health Important: If Item 27 any injury or other troone. Susan Stinnett - Niece 20b. Place of Disposition (Name of cemetery, crematory or other p Belair Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Belair, Maryland Jan.5, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Belair 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** End Stage disease or condition resulting in death) /Medical Due to (or as a consequen of) Examiner Diabetes sequentially list or distinct if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed por lipitemia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? \$ 101113m 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **□**1√0 1 □Yes 2 🖅 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes / 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manny of Death ne Hospital or Attending Pin 24 hours after death. 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the P within 2. To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) \$52749 30. Name and duress of person who completed cause of death (Item 23a) (Type, Print) J. HIRPARA MD 7505 21204 OSIEY Drive, TUNSON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Ruth Ekas 02 P Jah 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner hospital AGINES Battimor 51 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🔀 F 92 01/23/1918 Baltimore, Director 216-05-1056 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, I'm Mcdical Examiner must be notified at Director MD Baltimore Baltimore 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5718 Mineral Avenue 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: Specify: White \$ If Yes, Give Year or Dates: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Food Industry 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Klemm Elizabeth K. Muenzing ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5718 Mineral Avenue, Baltimore, Maryland 21227 Linda Campbell (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If iter any Injury or off once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial 01/05/2011 Sykesville, Maryland 4 ☐ Denation 5 ☐ Other (Specify) ighat e of Funeral Service Lipensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Divation **Physician** Dreumond week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) signed by the attending physician and deed detached for use as the burial-transit the death certificate be executed e Il ension resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s this certificate has autopsy performe 1 ☐ Yes 2 □No 1 □Yes 2 1 No ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 □ Impatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: <u>o</u> Attending 5 Pending investigation 14 Natural 1 ☐ Yes 2 No 2 Accident Divisi 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō thin 24 hours at 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the Hosp within 24 hou To the Funer completely fil Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie an dana MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Bettemorem D 21229 MD 900 caton lagor. Van dank Da

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 05

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Fink 2, 8:30 A M Loretta Jessica January 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Meadows Baltimore Glen Arm 8. Date of Birth (Month, Day, Year)
Sept. 3,1917 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 💢 F Months Days Hours Min 93 Director Maryland 214-03-3042 Usual Residence of Decedent 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the invalcal Examinant and the notified at Director 1 ☐ Yes 2 X No Baltimore Maryland Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm U.S.A. Funeral 21057 Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√XNo Specify. þ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, It. Magnetic app. Once. College (1-4or 5+) Elementary/Secondary (0-12) 12th. Grade Tire Company BookKeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Benjamin Wachter Margaret Κ. Seibert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7653 Trowbridge Ct., NC Shirley King/ Niece Raleigh 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/06/2011 Oak Lawn Cemetery Baltimore 21. Signature of Funeral Service License 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore MD 23a. Part 1. Enter the disease, or shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Microscapolic ceresho vascular **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ned by the Ö 9 Unknown 9 Unknown ٣. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ sorrenam 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Uursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manuer of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending Injury after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year)

Jan 4, 2011 29b. Signature and title of certifier 29c. License number Charles Street Baltimore Ma 21204 Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC M DWW MO 16701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2011 park Registrar

DHMH 17 Rev 1/2001

11-00025 Nelvin Guedeoni		ub Felipe I- For State Registrar	Si	tate	r Print in B of Maryland	/ Depa	artmer		alth an		al Hygi	ene Reg	g. No.	2011	0000.
Physicia: Medical Examin		Decedent's Nar	ne (First, Midd	le,Last	NELVIN (GUEDE	ONI (CHUB F	ELIPI	Ξ		Pate of Death Month anuary 1,		Year	Time of Death 1230 hrs
\bigcirc		4a. Facility Name 2902 Lanc		on, give	street and number			4b. City		Location of		, ,	4c. C	ounty of Death	
Funeral Director		5. Social Security	Number	6. Se	x 7. Ag	ge (In yrs. I	last birthda 28		nder 1 Yea			Date of Birth ugust		Foreig	thplace(State or In untry) Guatemal
any	- 1-	Usual Residence 10a. State	of Decedent 10b. County			10c. City	, Town or I	Location							10d. Inside City Limits
A	۱,	MD	Prince	∍ Ge	eorge's	Ну	attsv	ville							1 X Yes 2 No
Maryla 28a-f dato	Director	10e. Street and N	ımber					10f. 2	Zip Code			10	g. Citizer	of What Cou	ntry?
the the		2902 Lan	cer RD						20782				ıater		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f show iojury or other traumatic eveot, the Medical Examiner must be notified at once.	Fune	11. Marital Status 1 X Never Marr 3 Widowed	_		If Yes, Give Year			3. Was Dece If Yes, spe	cify Cuba	n, Mexican,	Puerto Rica	ın, etc.)		Race - Ameri White, etc.	can Indian, Black,
ntural'	g A				or Dates: ly highest grade co	mpleted)	16a. Dec	cedent's Usu	al Occupa	tion (Give ki	ind of work			d of Business/	
16 n 72 hc	Completed	Elementary/Sec	ondary (0-12)		College (1-4 or	5+)		ing most of v	_	o. DO NOT u	ise retired)				
-003 I withi Bene.	Ē.	6 ¹¹ 17. Father's Name	(First Middle	Last\			Ro	oofing		18 Mother's	Name (Fir	st, Middle, M		nstruct	ilon
21215-0036 uld be filed within 7 Mental Hygiene. marked other thaso	Be				sto Chub	Во					,	Felipe		•	
21 hould 1 is mar itic ev	e	19a. Informant's N					- 0.0							or Town, State	
MD and 2 sho saith and em 27 is	- L	Eric Chul 20a Method of Di)е	(Brothe			24 Bre			#202			t, MD 2	
Baltimore, permit. Pages I ar. Department of Hea Important: If itel				n 3[Removal from S	tate	crematory	or other pla	ce)					-	
Itim	+	4 Donation 5			99	Co		tario			01/13				n Luis Pete Latinos, In
Depa Depa Imp	1	Down	1//	16	B. Hute		- 1			-				, DC 20	CA 1820-
Physician	7	23a. Part I. Enter f	the disease, or	compl	ications that caused	d the death	. Do not e	nter the mod	e of dying	, such as ca	rdiac or res	piratory arres	st, shock,	, or heart	Approximate Interval Between Onset and
/ /Medical Examiner	i	Immediate Cause or condition result	(Final disease	a.l	Hanging										Death
	-			b	Due to (or as a cons	sequence o	of):								
	힐	Sequentially list of if any, leading to i	mmediate		Due to (or as a cons	sequence o	of):								
	탈	cause. Enter Und (Discess or injury events resulting in	that initiated.	C.	Due to (or as a cons	sequence o	of):		-		_				
		events resulting if	death) Last	d	,										
be exe	8	UNPENDE)		AMENDED			·							
Division of Vital Records, P.O. Box 68760, the Hospital or Atteodiog Physician: The law requires that the death certificate be ex in 24 hours after death. the Fuorral Director: After this certificate has been signed by the attending physician upletely filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was deceden past 12 month 1 Yes 2			23c. If yes, outco		2	Fetal dea		Ectopic	pregnancy			Date of delivery onth) Day Year
S, P.O. E inres that the d	2	Part II. Other sign	ificant condi	tions	contributing to dea	th but not r	esulting in	the underly	ing cause	given in Par	t I			e contribute to	the cause of death?
Records. The law required to the law required to the law peer 2 should	Completed										-	24a. Was an autops perform	y n <u>ed</u> ?		topsy findings available completion of cause of
Vital Reorgision: The his certificate director, page	Re C	25. Was case refe examiner?	rred to medica	300					26.Plac	e of Death (0	Check only	one)			
og Physical Company of After this Funeral direction	<u> </u>	1 🗸 Yes	2 No			ent 2			DOA					e 6 🗸 Other	: Scene
ivision of a for a street of a street of a street of a street of the result in by the funeral	Certification:	27. Manner of Dea 1 Natural 2 Accident	5 Pen	ding stigatio		Year)	FOUNE 1200 hi	rs	1	ıry at Work? Yes 2 🗹 I	No Sub	Describe ho	ed sel	f 	
Divisior Hospital or Atteod 24 hours after death Fuoeral Director:		3 ✓ Suicide 4 Homicide		Id not b					ory, office	building, etc		or Town, Sta	ate)	Number or Ru yattsville, MD	ral Route Number, City
o the Hos ithin 24 h	ल्	29a. Certifier 1 ☐ (Check only 1 ☐ one) 2 ✔			an: To the best of name of the basis of exa										

Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year)
Registrar JAN 0.6

ORIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 2, 2011

DHMH 17 Rev 1/2001 OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FINE .40 а RICHARD 2011 ANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON GREATER BALTIMORE MEDICAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours 0571771960 218-58-5669 50 MD **Director** Usual Residence of Decedent or 28a-f show Director 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21208 USA 12 MARCIE WOODS COURT 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò ģ 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Divorced 4 Divorced WHITE "natural" Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ATTORNEY 5+ LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HOWARD FINE CAROL SHAPIRO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHERINE FINE/WIFE 12 MARCIE WOODS COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 01/05/2011 OWINGS MILLS, MD 4 Donation 5 Other (Specify) re of Funeral Service Lic-22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy certificate has death? 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. 28d. Describe how injury occurred Certificate: injury 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C 29a, Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dean occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 2011 M.D.

State Registrar 6564

31. Date filed (Month, Day, Year)

Smitt 205

Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles

5+

			e ase Type Sta								II Copie Iental Hy		_	ible.	0001	1
		For State Registrar				•	rtificate					Reg. N	LU		0004	
Physicia		Decedent's Name (First, Mid MARVIN	rdle, Last) FROST								2, Date of De Month JANUA	Di	ay 20	Year 1 1	3. Time of Death 12:59 P	
Medic Examin		4a. Facility Name (if not institut		nd number)			4b. City,	Town, or	Location of	of Death	OHNOH		c. County		1 12 . 00 1	
		MAPLE HILL A 5. Social Security Number	SSISTED 16. Sex			last birthday	LA ¹	JREL 1 Year	If Under	24 Hrs	8, Date of Bi	rth.	HOW		Jaco (Ctata as Fare	inn
Funeral Director		071-20-9629 Usual Residence of Decedent	1 X M 2		83	ast birthday) Yrs.	Months	Days	Hours	Min.	09/18/	T927		Goun	place (State or Fore try) NY	ign
ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	10a. State 10b. Cour	oward		10c. Cit	ty, Town or Lo		-						1	0d. Inside City Lim	
the M		10e. Street and Number	OWARD		1	COLUI	10f. Zip	Code				10g. C	itizen of V	Vhat Cour	itry?	
h with ns 23a nust t	Funeral	7112 EDEN BR						2104					USA			
ar deat or iten niner r	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ N	Arr	s Decedent ned Forces? Yes 2	?		Was Deced If Yes, spec	ent of His	spanic Ori n, Mexicar	gin? (Spe ı, Puerto	cify Yes or No- Rican, etc.)			e - Americ k, White,		
ırs afte ıral", I Exan	ed b	3 XWidowed 4 ☐ Divord	If Y	es, Give ar or Dates.	110		1 🗌 Yes	2 X No	Specify:				Specify:	W1	HITE	
72 hou	Completed		dent's Education ghest grade com			(Give	dent's Usua kind of wor	k done d		t of worki	ng	16b. I	Kind of Bu	usiness Ind	dustry	
within giene.		Elementary/Seconday (0-12	c) Col	llege (1-4 or 4	5+)	ADVER	OO NOT use TISIN	,	ECUTI	VE			NEWS	PAPE	3	
e filed trail Hyge ed oth	To Be	17. Father's Name (First, Middle	•						18. Moth	er's Nam	e (First, Middle	, Maiden				
ould bould by Mer mark	Г	SAMUEL 19a. Informant's Name/Relation		FRIEDM	<u>IAN</u>	19h Maili	ing Address	(Street a	LEN		l Route Numb	er City o		HWAR'		
d 2 sh alth ar alth ar 27 is er trau		BETSY ADELMA		-		1	_				COLUM	-		210		
permit. Page 1 and Department of Hea Important: If item any injury or other once,	/a = 3	20a. Method of Disposition 1 XBurial 2 Cremati		al from State	e c	Place of Disponentery, cre YM SAL	matory or o	ther place			Date 5/2011	1	ocation -	•		
permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Othe 21. Signature of Funeral Service	* * * * * * * * * * * * * * * * * * * *	1.0	ПА		2. Name an		i_		L LEVI					
permi Depar Impo any ir		> Scott /	h WI	Her						OWN	ROAD,	PIKE			4D 21208	}
and the second		23a. Part 1. Enter the disease, shock, or heart failure. Li				th. Do not ent	ter the mode	of dying	, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
hysician/ Medical		disease or condition resulting in death)	a	Due to (or as	a consequ	uence of):								4	3 years	
Examiner	<u>.</u>	Sequentially list conditions,	b. —	Pr		nonia									month	
red	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	▗	Due to (or as	a conseq	uence of):										
executed an and rial-transit	_	that initiated events resulting in death) Last	c. <u> </u>	Due to (or as	a conseq	uence of):										
ate be ex physician the buria	edica		d											-		
eath certifice attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If y	es, outcome	e of pregna	ancy al death 3 [Ectopic r	regnanc	v				23d. Dat	te of delive	ery	
e death the att	ysici	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4 [☐ Pregnant ☐ Unknown	at time of		Other (sp		,				Moi	nth	Day Year	
s that the de gned by the ne detached	by Pr	Part II. Other significant cond	itions contributi	ng to death	but not res	sulting in the	underlying o	ause giv	en in Part	l.	23e. Did				e cause of death?	
w requires that s been signed t should be det	eted												/		pably 4 Unkno	
sician: The law i certificate has b lirector, page 2 s	Completed										24a. Was auto perf	psy ormed?	F	orior to co death?	osy findings availat mpletion of cause	of
lysician: T is certifical director, p	Be C	25. Was case referred to medic examiner?						26. Pla	ice of Dea	th <i>(Checl</i>		2441	NO[163	2 110	
Physic this ce	ျ	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospita	l: 1 lnpa a. Date of ini		ER/Outpatie		Othe Bc. Injury	4 ∐ Nı		me 5 Res				Assisted L	vi
nding ath. r: After e funei	icate	1 🄀 Natural 5 ☐ Per		(Month, Da		injury	M	work'			zad. Describe	now inju	ry occurre	30		
To the Hospital or Attending Physician: The law requires that the death certificate be exwirin Euhours after death, within Euhours after death. To the Fuhours after death conflictate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian	Certificate:		ald not be 28e	. Place of In building, e		ome, farm, st	reet, factory	, office			28f. Location (City or To			er or Rural	Route Number,	
lospita 4 hours 'uneral ed filled	Medical		ing Physician: T												d. use(s) and manner s	stated
o the hithin 2, o the F	Me		ing Nurse Pract				death occur		time, date			ne cause		inner as st	ated.	_
⊢ ≶ ⊢ Ó		Dany Se	11 /1	Chr	مر				1835	54			3/2			
6 V		30. Name and address of person	on who complete			n 23a) (Type,		y	Pasa	den	a MT	> ~	11122)		
Stat		31. Date filed (Month, PA) Pea	96 2011	32. Fegist	rar s Signa	ture	1	1	, , ,		7		1.00			
Registra	ar		- ~ LUII	Line	un	pl. 14	Jarke	-								

DHMH 17 Rev 7/2009

			State of Maryland / Department of Health and Mental Hygiene	
			Registrar Certificate of Death Reg. No.	042
	Physic	ian	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Charles Other Fisher, Sr.	of Death
· more	/Medi Exami		Jan 3 2011 5:25	PM "
and the	LAGIIII	ici	Genesis HealthCare - The Pines Easton Talbot	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State	or Foreign
	Director		218-14-9593 1 M 2 F 86 Yrs. Months Days Hours Min. Dec. 27, 1924 Country Mary La	ınd
	yland yow		10a. State 10b. County 10c. City, Town or Location 10d. Inside (Dity Limits
	a-fsh	cto	MD Dorchester Hurlock	s 2₺No
	or 28	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	s 23a	eral	4307 East Pheasant Drive 21643 USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment must be notified at once.	by Funeral Director	If Yes Give 1 Tyes 2 MNo Specific White	
Maryland 21215-0036	hours tural'	ed b	3 ☐ Wildowed 4 □ Divorced Year or Dates: 1943-89 Specify: WILL Specify:	
215	in 72 en "na Madie	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
217	d with	Com	Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical	
ng	be file	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Z	d Mer marke	ပ		
	1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than "ther traumatic event, the Menter traumatic event, the Me		19a. Informant's Name/Relationship (Type. Print) David Fisher Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 East Pheasant Drive; Hurlock, MD 21643	
Baltimore,	Pages 1 nent of H int: If iter		20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City or Town, State	
Iţin	artmer artmer ortant: Injury		4 Donation 5 Other (Specify) Carrison Forest 1/13/2011 Owings Mills, MD 21. Sign ture of Funeral Service Using	
Ba	permit. Departr Imports any Inju		Funeral Home of Catonsville, Inc.	20
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxima shock, or heart failure. List only one cause on each line. Approximation and the death of the deat	
-	Physician	N	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition The state of the	Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	,,
	LXammer	<u>ا</u>	Sequentially list conditions, If any leading to immediate cause. Enter Underlying	
	uted d insit	Examiner	cause (Disease or injury that initiated events	
oʻ	exectan and rial-tra			
68760,	ficate be executed physician and s the burial-transit	dical	d	
	ertific ling p e as t	Med	IF FEMALE:	
Вох	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Letopic pregnancy 23d. Date of delivery in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day	Year
O.	9 9 9	ysid	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) Month Day 9 Unknown	
σ.	The law requires that the date has been signed by the page 2 should be detached	by Pł		death?
of Vital Records,	equire	ed b	1	Linknown
ec	e law re has be e 2 sho	Completed	24a. Was an autopsy findings autopsy prior to completion of	available
E	75	Con	performed? death? 1 \(\text{Yes} \) 2 \(\text{Mo} \) 1 \(\text{Yes} \) 2 \(\text{No} \)	ause of
VIE	Physiclan: The this certificate ral director, pag	Be		
ō	ding Physiclan:). After this certific funeral director,	Certification: To	1 ☐ Yes 2 ☐ No Properties: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
Division	ath. r: After e funer	atio	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 2 ☐ Accident investigation 4 Injury	
<u>≤</u>	l or Atten after deat Director: I in by the	tific	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	nber,
	nital o rrs aft ral Di lled in			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			1 (40 Cul R133336 TANIMANY 4.2	011
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	-Sta	·0	AMY REESINE, CRNP GIO DUTCHMANS LANE LASTON, MD 21601 31. Date filed (Month, Day, Year) - 32. Registrature	
	Stat Registra		JAN 0 5 2011 June S. Barks	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FLOYD A M 8:15 V ω LAJANUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST RAHDALLSTOWN BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 (Mostle Cay, 1) 9739 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🌠 F Months 216-36-359 Director Usual Residence of Deceden 28a-f shov 10a. State traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director timore DM 1 **Y**es 2 □ No 10e. Street and Number 23a or 10g. Citizen of What Country? Funeral 21207 lom or items within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 Mo Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) 0 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau William N. Floyd (Huspand) lomber Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State **№** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee reene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** BACTEREMIA 48 HOURS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transif the Hospital or Attending Physician: The law requires that the death certificate be executed URINARY TRACT INFECTION Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Director: After this certificate I performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 은 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Detailing Trystocation and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature 29c. License number MD 00060293 JANUARY 2011 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 21133 DHMED M.D. 5401 RANDALLETOWN MURTUZA OLD COURT LD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

JAN U4

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hyg 1 – State Registrar State Certificate of Death	0011
1. Decedent's Name (First, Middle, Last) 2. Date of Deat	g. No. 3. Time of Death
Physician/ Medical Marcella Marie Fise January	1, 2011 1:45 P M
Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	Baltimore 9. Birthplace (State or Foreign
Director 233-01-7023 1 M 2 XF 90 Yrs. Months Days Hours Min. August 18	Year) Year) West Virginia
To log the state of because th	10d. Inside City Limits
10c. City, Town or Location 10c.	1 🗌 Yes 2 💢 No
9 5 9 10e. Street and Number 10f. Zip Code 1	Og. Citizen of What Country?
2300 Dulaney Valley Road Apt. W301 21093 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)	USA 14. Race - American Indian,
1 Never Married 2 Married 1 Yes 2 No	Black, White, etc. Specify: White
The state of the s	6b. Kind of Business Industry
College (1-4 or 5+) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Secretary	District Court of Md.
To positive secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Marcolle) 19. Feducand C. Marcolle	
Ellen Blake Ellen Blake	
The set of	
20a. Method of Disposition Date Date Date Date D	Oc. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation of Other (Specify) Entombrent Dulaney Valley Cem. Maus. 1/5/2011	Timonium Maryland
Mr. Robert E. Fise (Son) Set State Stat	
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinatory arrespinatory arrespinatory arrespinatory. Physician/	O set a, d Death
disease or condition resulting in death) a. Due to or as a consequency of):	3 days
1 energy	10 yrs.
- Cause Enter Underlying	
Due to (or as a consequence of): Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last Cause. Disease or injury that initiated events resulting in death) Cause. Disease or injury that initiated events resulting in death) C	
FFEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	23d. Date of delivery
W C C C 1 1 C C C 1 1 C C C C 1 1 C C C C 1 C	Month Day Year
SPICO Spice of the second of t	acco use contribute to the cause of death?
Paecords, 1	24b. Were autopsy findings available
A T The law and t	prior to completion of cause of death? No 1 Yes 2 No
25. Was case referred to medical examiner? 1	2010
Describe how 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how	
28d. Describe how 38d. Describ	injury occurred
The part of the pa	et and Number or Rural Route Number, State)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause	place and due to the cause(s) and manner stated
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the course of the	ause(s) and manner as stated. d. Date signed (Month, Day, Year)
Quotive Treis CRI R043580	1/3/2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Justine Preis, C.R.N.P. 2300Dulaney Valley Rd.,	Timonium, MD 21093
*/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G911 1/05/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ JÄNUARY ď³, 20 Î Î FRANK 6:40P M MARCY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 - M 2 X F Months Hours Min. Country) MEXICO 0677071949 Director 212-80-6383 61 Yrs Usual Residence of Decedent 28a-f show 10a. State 10h County death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 2800 STONE CLIFF DRIVE, #106 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 9 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", 3 Widowed 4 Divorced Specify Completed WHITE Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the 5+ SOCIAL WORKER DRUG DEPENDENCY Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, in once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ 1 and 2 should be if Health and Ments SIGAL BORIS VITTIA MOISEEV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₉₆₀₇₉ 06070 CLAUDIA ENGLISBY/DAUGHTER 41 SQUADRON LINE ROAD, SIMSBURY, CT 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PK. : 01/04/2011 REISTERSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Metromore cancer Medical Due to (or as a consequence of): Examiner Sequentially list conclitions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached Part II. **Other** si**gnificant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 Wo 1 Yes 2 🗆 No filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 🛕 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injufy occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

670 i

N

17

Chanis

Touson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L NOTE

5

31. Date filed (Month, Day, Year)

CHARLES

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00046 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear GLORIA FRAZIER 1210 PM Medical $2\Omega/$ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL ANNE ARKUDEL ANNAPOLIS 6. Sex If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year Jan 16, **Funeral** 9. Birthplace (State or Foreign Hours Min. Country) Maryland Director 212-40-0935 1942 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🙀 No Sussex Co. Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 313 Laurel Commons Lane 19956 United States 11. Marital Status 12. Was Decedent Ever in ILS. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 and Mental Hygie is marked other Production Technician Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Irving Stallings Cecilia Boswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Bentons Pleasure Road Mrs. Dawn Morsell / Daughter Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 01/07/2011 Glen Burnie, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Singleton Funeral & CremationM01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
7 1 2 4 2 5 Immediate Cause (Final Physician/ BREAST disease or condition METASTATIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day ate has been signed by the page 2 should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUTROPENIA DUE TO CHEMOTHERAPY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? Yes 2 No 25. Was case referred to meetica examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ♠ No Hospital မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying in instance of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 038328 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER ANNADOUS 2001 HOSP ITALPARKWAY MARY RCLANC MO ANNE ARVNOEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 Year 7 gerzid 06PM Jau mos Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 110ms (an Westminste (SWS) 10 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Min. July 30. 213-30-7941 Hours 75 Director Yrs **1**935 Usual Residence of Decedent 28a-f show the Maryland aţ 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 ☐ Yes ※XX No MD Carroll New Windsor ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4019 Franklinville Rd. **Inited States** 21776 within 72 hours after death with 12. Was Decedent Ever in 951— Armed Forces? I 951— 1 2 Yes 2 N 1961 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Black, White, etc. "natural", or ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Fire Fighter Baltimore City Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental of Health and Mental fitem 27 Is marked or other traumatic ever John Fitzgerald Anna Slaughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Molloy (Daughter) 4019 Franklinville Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any Injury or o o Page 1 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem Gardens 1/6/2011 Finksburg, MD Signature of Funeral Serv Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition YOUND (7) Ph sician/ Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

Yes 2 No death? this certificate 1 Yes eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to nedica 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year) W0059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mn(295 toner 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month do January 10:58 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death Se cours more Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y July 10, **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Min. Hours 218-78-2864 Country) Director 53 Maryland Usual Residence of Decedent shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 111 West Road 21204 United States 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0. Black, White, etc. Completed by 1 X Yes 2 [If Yes, Give Year or Dates Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 X No Specify: than "natural", 3 Divorced 4 Divorced Specify White or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. <u>Dis</u>abled Disabled marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked John J. Grelli Marie Concordia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ross / Sister 1325 Pinegrove Ave., Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) injury (Metro Crematory Inc. 101/06/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of FacilityCremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) per Kalpmra Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Stage the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed been s 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death? 2 - No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending Natural injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) s of person who completed cause of death (Item 23a) (Type, Print) 2000 State 6 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #5 Per FH G911 1/18/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month GANTT MICHAEL LORENZO 3.05 PM 2011 Tanuary 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death DCH PAVENVA COMMUNITY HUIND CIR BALTIMORE MD BALTIMORE 5. Social Security Number 8678 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 1 XM 2□ F Months Days Hours 56 217-66-6678 Sept 6,1954 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√∑Yes 2 □ No N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 McCulloh Street 21217 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 X Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Gantt Joan Winifred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Harris, Jr. / Brother 1024 N. Fulton Ave., Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/05/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland Ş 299 Frederick Rd., Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): jeals IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2) 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTED examiner' 1 ☐ Yes 2 ▼ No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA LIVING 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0070441 Famulcinua M.D

Hospital or Attending Physician:

Registrar

Physician

Examiner

Director

Funeral

þ

Completed

Be 2

Funeral

Director

ahow

r than "natural", or items 23a or 28a-f ahov the Medical Evar, free must be notified at

death with the Maryland

within 72 hours after

Hygiene.

other

ages 1 and 2 should be filed vont of Health and Mental Hygie t: if itam 27 ia marked other if y or othar traumatic event, IL

permit. Page Department o Important: If a

Physician

/Medical

Examiner

use as the burial transit and

physician

the detached

signed by

peen

certificate has

this

After

after death Director:

within 24 hours a To the Funaral D

director.

filled in by

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

à

Be Completed

Certification: To

cai

Ith and Mental Hve

Pages

Baltimore, Maryland 21215-0036

/Medical

31. Date filed (Month, Day, Year) **JAN 06** 2011

ABISOLA FAMAKINDA M.D. 3900 LOCH RAVEN BLVD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 18,19a,b per inf 2911 1-18-11 yr. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harry creene, Month Year Medical Januar 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown <u>Baltimore</u> Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs **Funeral** Birthplace (State or Foreign Country)
 MD 8. Date of Birth 1 X M 2 D F Months Hours Min. 1(Month, Per Year) 85 Director 219-18-8386 Usual Residence of Decedent show item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD n/a Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral death with 3508 White Chapel Road 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rmed Forces?

Yes 2 \[\sum \] No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: African-American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry I Greene Sr. Bertha Anderson Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Malli<mark>gt Adders (Scepted</mark> Number or Rural Route Number, City or Town, State, Zip Code) 3319—**Green Mead**, Koad, Windson Mill, MD 21244 Jacqueline Sherrod/Wife Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans 1-12-2011 Department of H Important: If ite any injury or ot 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 22. Name and Address of Facility lie Funeral Tone P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Metastatic Luna Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🖺 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 115 Rayapahrem D DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Ray a pakke, M.D. 2835 Smith AV. S. 203 - Balhimure, M.D. 21209 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

JAN 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2011 P^{M} Maurice Leighton Greenough 6:00 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ingleside at King Farm Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 M 2 □ F Months Days Hours Min. Director 011-14-1634 92 December 30, 1918 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28....any injury or other traumatic event, Its Marson. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 616 Aster Blvd. 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1945 — If Yes, Give Year or Dates: 1946 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Brown Greenough Bessie Elora Worthen ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nevell L. Greenough /Son 62 Nancy Drive, Hamilton, New Jersey 08619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc January 6, 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequent Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 □ Natural 2 □ Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29b. Signature and title of

6 Could not be determined

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1000 5757 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7133 Mill Run Drive, Derwwod, Maryland 20855 Ahmed Heshmat, M.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

JAN 06 201

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nó.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Magdalene M.E. Griswold D2011 Jamuary 3. 1:20 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) Germany 2/4/1918 Year) 1 □ M 2 🛣 F Days Hours Min. Director 217-64-3903 92 Vrs Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Mary land Parkville Baltimore 1 Yes 2 No 10e. Street and Number 10 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8800 Walther Blvd # 306 North 21234 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? "natural", or 1 Never Married 2 Married Completed by should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Kindergarten Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Johann Heinrich Wittenberg Charlotte Wilhelmine Luise Kemper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald P. Griswold / Son <u> 28 Bideford Court Baltimore, Maryland 21234</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/2011 Towson, Maryland 22. Name and Address of Facility RUCK TOWSON FUNETAL HOME. INC. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Dementia, Multi-infarct Onset and Death Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as extra the control of the cont Examine Due to (or as a consequence of): physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 Yes 2 No filled in by the Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signatur R171944 desp, MISN no completed cause of death (Item 23a) (Type, Print) 5800 Walther Blvd, Parkville MO 2/234 CRAP

State Registrar

Division of Vital Records, P.O. Box 68760

Masdaler

Ginzwold,

32. Registrar's Sign

Physician/ Medical

Examiner

Funeral Director

Be Completed by Funeral Director

မ

Pleas	se Type or Pri				-	_	ble.
For State Registrar	State of M	aryland / Dep Ce	partment of ertificate of		,	giene Reg. No.?	11 00053
1. Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Time of Death
	uld				Month Ja	Day .nuary 1,	Year F.O.2 TW
4a. Facility Name (if not institution, g	give street and number)		4b. City, Town, o	or Location of Deat	h	4c. County o	f Death
Stella Maris	Hospice			Luther	cville	Bal	timore
217-20-6852	6. Sex 1 □ M 2 🗷 7. Age	e (In yrs. last birthday, 84 Yrs.) If Under 1 Year Months Days			(Year)	Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	_ocation				10d. Inside City Limits
MD		Doltá.					1- Yes 2 □ No
10e. Street and Number		Baltin	10f. Zip Code			40 000	
1001						10g. Citizen of Wh	
1201 Cooks La			212:				d States
1 Never Married 2 Marrie	12. Was Decedent E Armed Forces?		 Was Decedent of H If Yes, specify Cub 	Hispanic Origin? (Sp an, Mexican, Puert	oecify Yes or No- o Rican, etc.)		- American Indian, White, etc.
3 ☐ Widowed 4. ☑ Divorced	If Yes, Give	No	1 🗆 Yes 2 🖼	Specify:		Specify:	
15. Decedent	Year or Dates.	1 10 2				орослу.	White
(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 or 5	(Give	edent's Usual Occup e kind of work done DO NOT use retired,	during most of wor	king	16b. Kind of Bus	iness Industry
12 17. Father's Name (First, Middle, Las		Sa	ales			Retai	.1
George Smith 19a. Informant's Name/Relationship Arlene Moose	(Type, Print) /Sister	7	iling Address (Street	Mary and Number or Ru		City or Town, Sta	te, Zip Code) MO 64735
20a. Method of Disposition		20b. Place of Disp	position (Name of		Date	20c. Location - C	
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ematory or other pla ake Cremat	<i>'</i>	Jan 04, 2011	Belts	ville, Maryland
21. Signature of Funeral Service Lice			22. Name and Addre		2011	DOLES	ville, narytana
2. 1. 0. 6	ROOM	1443 2	Cremati	on and Fur			
23a. Part 1. Enter the disease, or co shock, or heart failure. List on! Immediate Cause (Final disease or condition resulting in death)	y one cause on each line a. CEREBRO	the death. Do not en	iter the mode of dyir	g, such as cardiac	or respiratory arre	Towson M	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	С,	consequence of):					
I SERVALE	d,						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Petal death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of Month	•
Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?
					1 🗆 Ye	V	☐ Probably 4 ☐ Unknown
					24a. Was ar autops perforr	y prid n <u>ed</u> ? dea	re autopsy findings available or to completion of cause of ath?
25. Was case referred to medical			26 PI	ace of Death (Chec		∠ADJNO <u>I</u> 1L	Yes 2 No
examiner? 1 ☐ Yes 2 X No	Hospital:		Oth	Dr.		XF.	Hogge
27 Manner of Death	1 L Inpatie	nt 2 ER/Outpatie	ent 3 🗆 DOA	4 L Nursing H	ome 5 L Reside	nce 6 🔼 Other (Specify) HOSPICE

within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

FRANCES GOULD

2

Medical Certificate: To Be Completed by Physician/Medical Examiner

		1 Yes 2 No 3 Probably 4 Unknown				
		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ★ No 1 □ Yes 2 □ No				
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)				
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ome 5 ☐ Residence 6 K Other (Specify) HOSPICE				
27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 No	8d. Describe how injury occurred				
4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

JACKIE JONES. 31. Date filed (Month, Day, Year)

JAN 0 4 2011

29a. Certifier

(Check only one) 29b. Signature and the

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:08 AM Year 201 1, January Physician/ Loretta Juliet Gardner Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Gilchrist Center for Hospice Care Baltimore Towson 9. Birthplace (State or Foreign 8. Date of Birth 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day Year) 1958 Germany **Funeral** Days Min Months Hours 1 M 2 N 52 212.78.0646 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State Examiner must be notified at Director 1 Yes 2 No Harford Bel Air MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5 United States 23a Funeral 21014 955 Richwood Rd. Apt. E Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 - No ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify White "natural", Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry Medical 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Retail the Sales Person Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H Gisela Gertrud Meta Hasert permit. Page 1 and 2 should be.
Department of Health and Menta.
Important: If item 27 is marked any injury over 1 ပ Robert Earl Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 606 Rivershore Ct. Edgewood, MD 21040 Brinagar /Son Christopher 20c. Location - City or Town, State Jan 04 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran or as a consequence of): Due to resulting in death) Last Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Day Month in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 L Yes 2 23e. Did tobacco use contribute to the cause of death? ↓II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 1 Yes 2 No 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 27. Manner of Death (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide
4 Homicide

Box 68760 P.O. Division of Vital Records, within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

> Year State Registrar

3

re and title

Name and address of pe

29a. Certifie

29b. Signa

(Check

only o

01

son who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Month Giffi 02:26 AM Frank JANUARY ZOIL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hopkins Bayview Medical Center Bultimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. Director 167-03-3835 94 April 10, 1916 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 103 Cherry Valley Road Funeral 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ٥, 1 ☐ Yes 2 🛣 No ₽ Specify. 3 X Widowed 4 ☐ Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, I'm Once. Manager Sweetheart Cup Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmine ည Giffi Clotilda Judice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Giffi - son 303 Blue Grass Ln, Hampstead MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/8/2011 St. Leo's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Ridgway , PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reisterstown, Maryland 21136 ELINE FUNERAL HOME 11824 Reisterstown Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory failure **Physician** hour /Medical Due to (or as a consequence of): Bleeding from inside the trached Examiner 30 minutes sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Gradual erosion of tracheal tissues To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Years Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🛮 Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Daz 2011 29b. Signature and title of certifier 29c. License number RES-000 January OZ, ZOIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Bultimore, MD 21224 Melinda Morton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parker Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** onuc Janua ,2011 /Medical lame (If not institution give street and number) 4b. City, 4c. County of Death Tewn, or Location of Death Examiner oseis Princes George's ace 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 18-260 Hours Months 1 □ M 2 Days Min. New York 6 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 X No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13426 Overbrook Lane 20715 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Ş 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filled wi tment of Health and Mental Hygier tant: If item 27 Is marked other th jury or other traumatic event, Ins Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nicholas F. Blain Julie M. Tacv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 Burns Lane Williamsburg, Susan Weismiller, Friend VA 23185 20a. Method of Disposition
1 ☐ Burial 2X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or once. 01/03/11 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, icause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Dire to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 mon 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 1 ☐ Yes 2 ☐ No 2 1NO director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner. 28b. Time of Injury 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director. Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated d Mile of certifie 29d. Date signed (Month, Day, Year)

(QV State

Registrar
DHMH 17 Rev 1/2001

(Month, Day,

2011

Year)

who completed cause of death (Item 23a) (Type, Print)

			Panto	epartment of Health and N	∕lental Hy	giene	alle arts I fell seems
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death		Reg. No.	00057
	Physicia				2. Date of De Month		3. Time of Death
,j=.	Medi Examir			4b. City, Town, or Location of Death	01	02 2011	/ /A M
40			St. Thomas More Nursing and Rehab	Hyattsville		4c. County of Death Prince Geo:	roets
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	th 9 Rirth	place (State or Foreign
	Director		226-24-2565 1 Louid Residence of Decedent 92 Yi	s. Months Bays Hours Will.	07 0	Ay, Year) Coun 6 1918	VA
	and show 1 at	ō		or Location		1	0d. Inside City Limits
	Maryl 28a-f otifie	rec	DC Washing	ton			1 X Yes 2 □ No
	h the	a D	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cour	ntry?
	ith wit	Funeral Director	4308 4th St. NW	20011		USA	
(0	or ite	by Fu		 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036	rs afte iral", Exan	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 No Specify:		Specify: Blac	ek
5-0	2 hou "natu edical	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed)	ecedent's Usual Occupation	ina	16b. Kind of Business Inc	dustry
121	thin 7 ene. than he Me	mo _S	Elementary/Seconday (0-12) College (1-4 or 5+)	Rive kind of work done during most of working to NOT use retired) 15ewife	ng		
d 2	iled w I Hygi other	Be	6th Hot 17. Father's Name (First, Middle, Last)	18. Mother's Name	First Middle	Maiden Surnamo	
/lan	d be fi Venta arked itic ev	은	Richard Slaughter	Champ Pa		<i>'</i>	
fan	shoul and l		19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rura			Code)
S.	and 2 Health In 27 Ther tr			08 4th St. NW Washin	gton,D(C 20011	
nor	age 1 and the first transfer of transfer of transfer of transfer of transfer of transfer		1 № Burial 2 □ Cremation 3 □ Removal from State cemetery,	crematory or other place)	Date	20c. Location - City or To	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Washing 21. Signatore of Funeral Service Licensee	ston National 01/0 22. Name and Address of Facility Mar		Suitland, MI	
B	Dep Imp any		Ant C. molern	4217 9th St. NW Was			L nome
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate
	flysicien/	60 VI	Immediate Course (First	Cardiovascular Dise	ease		Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):	out alloward bio	-450		
		ē	Sequentially list conditions, if any, leading to immediate cause. Eiter Underlying b. Due to (or as a consequence of):				
	ted nsit	Examiner	Cause (Disease or linjury				
	execu an and ial-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
09	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d				
587	ertifica ding p	/Me	IF FEMALE:				
P.O. Box 687	ath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ⚠ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify) _		23d. Date of delive Month	ry Day Year
Ö.	the dea by the a tached	hysi	1 Yes 2 2 No 9 Unknown 9 Unknown	3 🗆 Other (specify)		Worth	Day real
P.O	that tined b		Part II. Other significant conditions contributing to death but not resulting in ti	ne underlying cause given in Part I.	23e. Did to	bacco use contribute to the	e cause of death?
ds,	v requires that s been signed t should be det	Completed by	Anxiety		1 □ Y	res 2 □ No 3 □ Prob	ably 4 💢 Unknown
COL	law re nas be 2 sh	nple	Depression		24a. Was a	an 24b. Were autop	sy findings available inpletion of cause of
Re	sician: The la certificate ha irector, page 2				perfor 1 Yes	rmed? death?	∑ X No
ita	sician certif irector	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Check			
of ^	g Phys er this eral dir	은 등	27. Manner of Death 28a. Date of injury 28b. Time	e of 28c. Injury at 2		ence 6 Other (Specify) ow injury occurred	
OU	ending sath. or: Afte he fun	licat	1X Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation	y work? M 1 ☐ Yes 2 ☐ No	- D0001130 110	on injury socialized	
Division of Vital Records,	or Atter frer de irecto n by tl	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	8f. Location (St City or Town	treet and Number or Rural F	Route Number,
	pital c					•	
	e Hos 124 ho e Fun eleted	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, deal check only one) 1 ☑ Certifying Physician: To the best of my knowledge deal check of my k	vestigation, in my oninion, death occurred at t	he time date an	ad place, and due to the cour	co/c) and manner stated
	To the Nospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di		29b. Signature and title of configer	29c. License number		cause(s) and manner as state 29d. Date signed (Month, Da	
				D0063681		01/04/2011	
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		, _ , ,	
	State		Ajit Kurup, MD 4922 Lasalle Rd. Hy 31. Date filed (Month, Day, Year) 32. Registrar's Signature	vattsville, MD 20782			
	Registra	~	JAN 0 6 2011 Assure A. Assure	Carl			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Trem 17 per fh g911 1-6-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 247 John A. Hicks ranuari Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greneral etimore Age (In yrs. last birthday) Year If Under 24 Hrs. . Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min (Month, Day, Year) 218-38-3625 66 **Director** MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ll West 20th St. Apt.15G 21218 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes, Give 1 Yes 2 KNo Specify: Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled yrs none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hohn Hicks Dorothy Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin L. Hicks (Brother) 1318 Homewood Ave. Balto, Md. 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 14,2011 Balto,Md. cemetery, crematory or other place) 1 Burial 2 remation 3 Removal from State Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Calvin B. Scruggs Funeral Home Preston St Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown as been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page yes 2 No 2 🗌 No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 \(\subseteq No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kion mien-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 206 md < m 31. Date filed (Month, Day, Year) 32. Págistrar's Signature State JAN 0 Registrar (¥ DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1020A HEODORE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital of Ka BALTIMORE 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3 Director 28a-f shov 10c. City, Town or Location 10a. State 10b. County with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director RANDALLSTOWN 1 Yes 2 No BALTIMORE 10e. Street and Number 9 10q. Citizen of What Country? Funeral items 23a 21133 4.5.A. 5004 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) MERCHANT Elementary/Seconday (0-12) College (1-4 or 5+) COOK SEAMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDALISTOWN, MARYLAND Ra. OLD COURT 20b. Place of Disposition (Name of 20a. Method of Disposition 1 MBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 08/2011 4 ☐ Donation 5 ☐ Other (Specify) MEM, PARK BALTIMORE, MARIJAND DERRICK C. JONES FIH, P.A . Signature of Funeral Service Lice 22. Name and Address of Facility The BALTIMORE, MARYIAND 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 5407 disease or condition) Medical resulting in death) Examiner months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a son segui noe of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Mellitu Type 2 2 No 3 Probably 4 Unknown Completed Renal 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. Ineral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check 3 Certifying Nurse Practiceers To the best of my knowledge, death occurred at the time, date 29b. Signature and title of certifier 29c. License numbe 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Yea 1:25 PM ton eonard 60 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01 If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 DM 2 DF Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or forther traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State Director 1 Yes 2 No an 10g. Citizen of What Country? 10e. Street and Number Funeral 21/33 U3A . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in J.S. Armed Forces? 11. Marital Status Black, White, etc 2 1 Never Married 2 2 No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Blac 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during life. DO NOTyuse retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) မ Informant's Name/Relationship (Type or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural A 20a. Method of Disposition Place of Disposition Date 1 Burial 2 Cremation 3 Removal from State more -2*U*11 4 Donation 5 Other (Specify) Funeral Services 21. Signature of Funeral Service bicens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lytragrania dows Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examine burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours a fer death.

To the Funeral Director: After this certificate has completed filled if by the funeral director, page 2: autops, performed 2 1 Yes 2 No Yes 2 **Division of Vital** 25. Was case referred to -- dica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 -ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 3 [only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 188 191579

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Month, Day, Year)
JAN 0 5

11-00033	
Marquise Hall	

Marquise Hall	1	State For State	of Maryland /	Depart Certii	tment of I ficate of L	Health Death	and Me	ental Hy		ag Na	2011	00061
Physiciar	R	egistrar I. Decedent's Name (First, Middle,La	st)	007111				1	2. Date of Dea		1	3. Time of Death
Physician Medical Examin	L/A	Marquis	so, to						Month January	Day 1, 2011	Year	1718 hrs
	4	a. Facility Name (if not institution, gi	ve street and number)	-1			n, or Locatio	on of Death		4c.	County of Death	
		Johns Hopkins Hospital				Baltimor		- des Odlies	le Date of B	rth (A 4) 4 (5)	D/YYYY) 9. Birth	anlace (State or
Funeral		5. Social Security Number 6. S	٠	(In yrs. last		If Under 1 Months		nder 24Hrs. ours Min.	o, Date of B		Foreign	intry) M
Director	5	ALL SALANDE	M 2 F	10	Yrs.				52	1-19	94 600	illuy) NLD
au A		Usual Residence of Decedent 10a. State 10b. County		Oc. City, To	own or Location	n					Т	10d, Inside City Limits
B		MD		Ra	1.4m	OCT	2 2					1 No les 2 No
nylan la-f st	황	10e. Street and Number		DV	4 / 11/1	10f. Zip Co	de			10g. Citiz	en of What Coun	try?
he Ma ified	Director	628 NI. M.	Hour A	10	3	2	120	5		(ISA	
hours after death with the Maryland "natural", or items 23a or 28a-f show Examiner must be ootified at once.	ᅙ	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was	Decedent of	of Hispanic	Origin? (Specan, Puerto I	ecify Yes or N	0- 1	Race - Americ White, etc.	can Indian, Black,
death rr iten	Funeral	1 Never Married 2 Marrie	1 Yes 2	No			and the same of th		itiouri, oto.y		b	lock
after	2		d If Yes, Give Year or Dates:	14	6a. Decedent's		No spec	-	ork done		Specify: Spe	dustry
"natural",	р -	15. Decedent's Education (Specify	College (1-4 or 5-		during mos	t of workin	g life. DO N	OT use retin	ed)	100.10	-	,
36 in 72 has	ple	Elementary/Secondary (0-12)	College (1 4 of o		. 5	His	POAT	+		1/7	ancis	Mhbod
21215-0036 suld be filed within 72 Mental Hygiene. marked other thao	Completed	17. Father's Name (First, Middle, Las	st)			1000	18.Mol	ther's Name	(First, Middle,	Maiden S	Surname)	
215 e file ntai H iked o	Be (Margieette	1011				10	200	Ma	Ma	THI)
IMOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Inci: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic evect, the Medical Examiner must be notified at noce.	입	19a. Informant's Name/Relationship	(Type, Print)	Hez)	19b. Mailing	Address (Street and I	Number or R	ural Route No	ımber, Cit	y or Town, State,	Zip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	J	20a. Method of Disposition	rtin		ace of Dispositi	on (Name	of cemetery	700	Date	20c. L	ocation - City or	Town, State
Baltimore, MC permit. Pages 1 and 2 si Department of Health at Important: If item 27 injury or other trauma		1 Burial 2 Cremation 3	Removal from Stat	0.00	ematory or other		7		Links	17	2-140	MI
Firm Pag	1	4 Donation 5 Other Special 21. Sig Free Service Lice		Gre	envior	me and	dress of Fa	City	10/20	-	yar 10	
Bal permi Depar injury	ł	a war a family	0/553		I V	uiq	My	V V	ene	Ten	MD Q	13/2
Physician	+	23a. Part I. Enter the disease, or con	nplications that caused t	he death. D	o not enter the	mode of d	lying, such a	as cardiac or	respiratory a	rrest, sho	ck, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line. _{a.} Multiple Gunshot	t Wound	s		*					Death
Examiner	1	or condition resulting in death)	Due to (or as a consec									
	_	Sequentially list conditions,	bb	unence of).								
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.									
sit d	Examiner	events resulting in death) Last	Due to (or as a conse	quence of):								
and and	dical	UNPENDED	d				_			-		
Li gi b	03 -	IF FEMALE:	23c. If yes, outcom	e of pregna	ancy					230	. Date of delivery	,
1876 Hifteal Ing ph	N/W	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Feta	l death		topic pregna	ncy		Month [Day Year
Box 6876. e death certificate the attending phy ed for use as the te	sician/M	1 Yes 2 No 9 Unknow	4 Pregnant at t	time of deat	th 5 Oth	er (Specify	"					
. Be the de ched for the de	Phy	Part II. Other significant condition		but not res	sulting in the un	derlying ca	ause given i	n Part I.	23e, Did	tobacco i	ise contribute to	the cause of death?
ires that the signed by t	<u>る</u>		_						1 🗆 Y	es 2 🗸	No 3 Prob	oably 4 Unknown
ords, w require	eted								24a. Wa	s an opsy		topsy findings available completion of cause of
COT law r has b	Completed	·								formed?	death?	
Re ifficate rr, pag		25. Was case referred to medical				26	Place of De	eath (Check				
i of Vital Records, is Physiciae: The law requir After this certificate has been s funeral director, page 2 should 1	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸 E	R/Outpatient	3 DO/	A Other	4 Nursin	g Home 5	Reside	nce 6 Other	r.
of \ e Phy fer th neral	\vdash	27. Manner of Death	28a. Date of Inju		28b. Time of In	′ ′ I	c. Injury at V		28d. Describ Subject sh		ry occurred	
OD sath.	tio	1 Natural 5 Pending 2 Accident Investig	ation		1649 hrs		1 Yes 2	2 ✔ No				
Division talor Attendius staffer death.	ifica	3 Suicide 6 Could n	ot be 28e. Place of Inj	ury - At hor	ne, farm, street	, factory, o	ffice buildin		or Town	State)		ral Route Number, City
Opital Ours a peral I filled	Certification:	4 Homicide determine	(9200.19) [00								wood, Baltimo	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physocompletely filled in by the funeral director, page 2 should be detached for use as the b	edical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best of my	/ knowledge nination an	e, death occurr d/or investigati	ed at the ti on, in my o	me, date an pinion, deat	a piace, and th occurred a	due to the ca at the time, da	use(s) an te and pla	u manner as stat ce, and due to th	e cause(s)
To th withii To th	Medi	29b. Signature and title of Certifier	and manner stated.				License num				Date signed (Mo	
	-	1 / 1 / /	11.			(O.C.M.E.			Jan	uary 2, 2011	
,		30. Name and address of person wh	no controlleted cause of d	eath (Item 2	23a)	-						
)		Laron Locke MD. Ass	istant Medical Exa	miner	900 W. Ba	Itimore S	Street, Ba	altimore, i	MD 21223			
St	tate	31. Date filed (Month, Day Year)	32. Regis a	's Signatur	e 4	ark	j					
Regis		V 10 10 1 1 1	5 2011	un	1. 19	acres						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2011 Year John Henry Horn Jan 2 8:45am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Patuxent River Health Laurel Anne Arundel 5. Social Security Number If Under 1 If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □XM 2 □ E 216-07-6895 92 Sept.14,1918 MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Laurel 1 ☐ Yes ▼☐ No 10f. Zip Code 10g. Citizen of What Country? 7700 Cherry Lane 20707 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Policeman Baltimore COunty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry John Horn Margaret Massong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Horn / wife 7700 Cherry Lane Laurel MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 1/8/11 Baltimore MD 4 Domation 5 Dother (Specify) Funeral Sovice Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Part —Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Desidence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 □ No Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760,

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the buriel-transit use as t page within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, Hospitel To the within 2

Physician

/Medical

Examiner

Director

Funeral

<u>ک</u>

Completed

Be

Physician/Medical Examiner

þ

Be Completed

Medical CertIfIcation: To

examiner?

27. Manner of Death

2 Accident

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier

Natural

1 Yes 2 No

10a. State

MD

11. Marital Status

10e. Street and Number

<u> 12th</u>

21. Signatur

Immediate Cause (Final disease or condition resulting in death)

Funeral

Director

r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

death with the Maryfend

Pages 1 and 2 should be filed within 72 hours efter

Hygiene.

Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, III once.

Physician

Baltimore, Maryland 21215-0020

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 059 31. Date filed (Month, Day, Year) 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hall 6:55 Ellen H. 201 1 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 14737 Thornton Mill Road Sparks Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛚 F 215-30-6656 Months Min. (Month, Day, Yea 80 Hours Sparks, Maryland **Director** April Usual Residence of Decedent show 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Sparks 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 14737 Thornton Mill Road 21152 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian er than "natural", or iter the Medical Examiner Armed Forces? 1 Yes 2 XXNo Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Company Office Manager 12 Be t. Page 1 and 2 should be filed Ament of Health and Mental Hi rtant: If item 27 is marked otl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Zita Ensor Charles L. Huffard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hall - Son 14701 Thornton Mill Road, Sparks, Maryland 21152 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 1 Baltimore. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel and Cremation Services Pelair Jan. 4, 2011 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services — Monkton 16924 York Road, Monkton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final STAGE Physician/ SNO disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day 4 ☐ Pregnant 9 ☐ Unknown be detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hupertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records. Completed Hyperli pidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 X No 1 ☐ Yes 2X No 25. Was case referred to medical of Vital filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature completed cause of death (Item 23a) (Type, Print) N. CHARLES ST. BALTIMORE MARYLAN

Рм

Year

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:20 P/M 2ီဂိ**1** 1 William R. Jarvis Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Bel Air Upper Chesapeake Medical Center Harford 8. Date of Birth
(Month, Day, Year)
7, 1932 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Director 78 004-30-6118 Maine Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits the Medical Examiner must be notified at 10c. City. Town or Location Director MD Cecil Port Deposit 1 Yes 2 No 10e. Street and Number 10f. Zip Code 23a or 3 10g, Citizen of What Country? Funeral 21904 United States 160 Craigtown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1952 If Yes, Give Year or Dates. _____ -1991 ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than United States Elementary/Seconday (0-12) College (1-4 or 5+) Navy E-8 Militarv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Jewell William E.S. Jarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 160 Craigtown Rd., Port Deposit, MD 21904 Gracia Jarvis Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/05/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OSTRIBIUM Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LUNG CANCER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes ours after death. eral Director: After this certifica filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide 24 hours certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one D0056296 of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake JAN U 6 2011 Registrar

S

ARVI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** A M Roy Allen Jenkins January 1, 2011 5:20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wilson Health Care Center Montgomery

9. Birthplace (State or Foreign Country) Gaithersburg If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1 XM 2□ F Months Davs 82 579-30-1275 April 4, 1928 Director West Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Examinar must be notified at 1 X Yes 2 No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code e filed within 72 hours after death with all Hygiene.
other than "natural", or items 23a or Funeral 407 Russell Avenue #711 United States 20877 12. Was Decedent Ever in U.S.
Armed Forces?

1 TYPES 2 □ No 1952 −
If Yes, Give
Year or Dates: 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: <u>۾</u> Specify: White 3 X Widowed 4 □ Divorced 1954 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Architect Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental Ernest Beuford Jenkins Marie Sweig Carmene ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Stacy Fischbach/Daughter 5009 Scarsdale Road, Bethesda, Maryland 20816 permit. Pages 1 a
Department of Her
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January 7, Makemont Gardens 2011 Davidsonville, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. M01530 300 W. Montgomery Ave., Rockville, Maryland 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Schenne 1788 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 00 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 🗹 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04/65 VI Rapertainches 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
JAN 0 4 2011

32. Registrar's Signature

BIRSCHORLH, MAD

DHMH 17 Rev 1/2001

			_ FOI	Department of Health and	Mental Hygi	ene ·
				Certificate of Death	Re	9. No. 2 0 1 1 0 0 0 6 6
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
	Medic	al	Joseph Jackson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	<u>'</u>	
	Examin	er	University of Maryland Medical Center	Baltimore	Citu	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birti	hday) If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign
	Director			Yrs. Months Days Hours Min.	(Month, Day, Y	Year) Country) TX
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	laryla 3a-f s iffied	ecto	MD Anne Arundel	Linthicum		1 ☐ Yes 2 No
	the N or 2	οi	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?
	n with	Funeral Director	304 Darlene Avenue	21090		USA
	death r iten iner n		Aillied Folces:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
38	al", o	d by	1 Never Married 2 Amarried 1 Yes 2 No If Yes, Give 1 Year or Dates.	1 ☐ Yes 2XXNo Specify:		Specify: white
0-10	hours natur lical	lete	15. Decedent's Education 16a.	Decedent's Usual Occupation	1	6b. Kind of Business Industry
2	nin 72 ne. han " e Mec	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	rking	Committee
22	d with dygier ther t nt, th	Be C	12 2+	Network Security	uu - /Finat Adiaballa Ada	Security
Baltimore, Maryland 21215-0036	l and 2 should be file F Health and Mental H item 27 is marked o other traumatic eve	To E	Zane La Ray Jackson	18. Mother's Na	me (First, Middle, Ma ary E. Ge	isler
ary	nd Me s mar s mar umati		19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Ru	ır <u>al</u> Route Number, C	City <u>or T</u> own, State, Zip Code)
Ξ̈́	id 2 sh alth a n 27 it er tra	10	Deborah Ann Jackson / Wife	Mailing Address (Street and Number or Ru 304 Darlene Avenue,	Linthicun	a MD 21090
ore	elar of He if iten		1 Burial 2XXCremation 3 Removal from State cemeter	f Disposition (Name of ry, crematory or other place)		Oc. Location - City or Town, State
ţi	t. Pag tment tant: ijury o		4 □ Donation 5 □ Other (Specify) Arden		/4/2011	Hanover MD
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Vi	21. Signature of Funeral Service Licensee Victor Doda	22. Name and Address of Facility Larles L. Stevens	Funeral H	Home, Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do n			ore MD 21230
-4	h sician/	3 12	shock, or heart failure. List only one cause on each line.	F - 1		Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to for as a consequence of	piratery Failure		
	Examiner	ř	Sequentially list conditions, b. Acute Respire	Hory Distress Syndr	ome	
	sit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	ori):		
	ecute and Il-tran	Exal	that initiated events resulting in death) Last c. Due to (or as a consequence of	new Failure		
09	ath certificate be executed attending physician and for use as the burial-transit	dical Examiner	La Acute Liver	- Failure		
876	ificate ng phy as the	Med	IF FEMALE:			
Box 687	h cert tendir ir use	lan/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy			23d. Date of delivery
Bo	e deat the at hed fo	Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 U Other (specify)		Month Day Year
P.O.	es that the dea signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e, Did toba	acco use contribute to the cause of death?
S,	uires that n signed ild be del	Completed by	Lower Gastraintestinal bleed, Rhabdon	myolysis, ST elevation	1 ☐ Yes	s 2 No 3 Probably 4 Unknown
oro	v require s been s should	plete	Muscardial Infanction, Anemia . The	-ombocutopenia.	24a. Was an	24b. Were autopsy findings available prior to completion of cause of
3ec	The law ate has bage 2 s	com	Disseminated Intravascular Condular	1. 3.11	autopsy perform 1 Yes 2	ed? death?
<u> </u>	strifica ctor, p		25. Was case referred to medical examiner?	26. Place of Death (Che		
Ž	Physic this o	ပ္	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou 27. Manner of Death 28a. Date of injury 28b. T		1	ace 6 Other (Specify)
Division of Vital Records,	ding I th. After funer	Certificate:		ime of 28c. Injury at work? M 1 1 Yes 2 No	28d. Describe how	injury occurred
Sio	Attendar death	ırtifi	3 Suicide 6 Could not be 28e. Place of Injury - At home, fall			eet and Number or Rural Route Number,
Dί	tal or A	Ce	building, etc. (Specify)		City or Town,	State)
	Hospital 24 hours Funeral eted filled	Medical	29a. Certifier (Check (
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Ĭ	only one) 3 Certifying Nurse Practioner: To the best of my knowl 29b. Signature and title of certifier	edge, death occurred at the time, date and pl 29c. License number		ause(s) and manner as stated. Id. Date signed (Month, Day, Year)
	≓≶Ĕŏ		Scatt Raine MAN	NPI#1295050		1/3/2011
	'		30. Name and address of person who completed cause of death (Item 23a) (7 1 -	
			22 S. Greene St., Bultimore,	WD 51501		
	Stat Registra		31. Date filed (Month, Day, Year) 32. legistrar's Signature AN 0 5 2011	barker		

11-00009 **David Jones**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | |

		1- For State Registrar		Certificate of D	eath	Re	eg. No.	
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd	tathony	Jones		2. Date of Deat Month January 1,	Day Year	3. Time of Death 0601 hrs
	A.e.	4a. Facility Name (if not institution University Hospital	on, give street and number)		City, Town, or Location Baltimore	of Death	4c. County of Death	1
Funeral Director		5. Social Security Number 214-25-2882	6. Sex 7. Age (II	, , , , , , , , , , , , , , , , , , , ,	f Under 1 Year If Und Months Days Hou		h(MM/DD/YYYY) 9. Bir Foreig Co	thplace (State or in Many and untry)
und show any nce.	5	Usual Residence of Decedent 10a. State 10b. County	/ 10x	c. City, Town or Location Baltim	Ore			10d. Inside City Limits 1 Yes 2 No
h the Maryland 13a or 28a-f show	I Director	10e. Street and Number 4328 Fairh	laven Avi	10	0f. Zip Code 2 1 2 2	.6	Og. Citizen of What Cou	ntry?
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	/ Funeral	7	12. Was Decedent Everage Armed Forces? 1 Yes 2 Vorced If Yes, Give Yeer	If Yes,	ecedent of Hispanic Or specify Cuban, Mexica s 2 1 No specify		14. Race - Ameri White, etc.	ican Indian, Black,
7	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)			Usual Occupation (Give of working life. DO NO		16b. Kind of Business/I	ndustry
	Be	17. Father's Name (First, Middle,	Lest) Jones		Fa	er's Name (First, Middle, N	rlette	
e, MD 2121 s and 2 should be f Health and Mental item 27 is market traumatic event,	2	19a. Informant's Name/Relations	nes father	19b. Mailing Ad 29/3 20b. Place of Disposition	Bristol	Channel C	f. Pardal	Strua hol
imore Pages 1 nent of F.		1 Burial 2 Cremation 4 Donation 5 Other Signature of Fueral Services	pecify:	crematory or other;	e polace)	Jan 11 2011	Ba/fo	led.
Balt Departic Importation	1	23a. Part I. Enter the disease, or failure. List only one cause	complications that caused the	- 170	e end Address of Favil A Cull of Jones of Guille of Gui	h -T. Pal		Approximate Interval Between Onset and
/Medicul Examiner		Immediate Cause (Final disease or condition resulting in death)	CA-b Manada(O) a					Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated	С					
xecuted n and l - transit		events resulting in death) Last UNPENDED	dAMENDED	ence or):		_		
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - trans	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal d	leath 3 Ectop	ic pregnancy	23d. Date of delivery Month D	y Day Year
	2	Part II. Other significant condit	ions contributing to death bu	at not resulting in the unde	rlying cause given in F		bacco use contribute to	_
Records The law requestate has been page 2 should	Completed					24a. Was a autops perfor	sy prior to comed? death?	topsy findings available completion of cause of
Vital Physician: rthis certifi	To Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient 3	DOA Other		Residence 6 Other	
or: A	Certification:	27. Manner of Death 1 Natural 5 Pend 2 Accident Invest	stigation Jan 1, 2011	28b. Time of Injury FOUND: 0153 hrs - At home, farm, street, fa	1 Yes 2 ₩	Subject stab	ow injury occurred bed treet and Number or Ru	rai Pouto Alumbar, Cita
E G D		4 Homicide dete	(Specify) Other	(specify):street		or Town, St 1500 Hazel Av	ate) renue, Baltimore, MD	
To the Hos within 24 h To the Fun completely	Medical	(Check only 1 Certifying Pi	hysician: To the best of my kn miner:On the basis of examina and manner stated.	ation and/or investigation,	at the time, date and p in my opinion, death o	ccurred at the time, date a	e(s) and manner as state and place, and due to the 29d. Date signed (<i>Mor</i>	e cause(s)
		0	M. Ct		O.C.M.E.		January 1, 2011	
			outy Chief Medical Exar	miner 900 W. Balt	imore Street, Bal	timore, MD 21223		
St Regist		31. Date filed (Month, Day, Year) JAN 0 5 201	32. Registrar's S	Signature Sould				

Physician //Medical Examiner 4a. Facility Name (If not institution, sive street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death Funeral Director 5. Social Security Number 6. Sex 1	Inside City Limits 1 ☑ es 2 ☐ No 2 Indian,
Physician Medical Examiner	e (State or Foreign Inside City Limits Pes 2 No Region 1 Pes 2 No
Funeral Director 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	Inside City Limits 1 Pres 2 No 1 Indian,
Director Usual Residence of Decedent Social Security Name Superior Sup	Inside City Limits 1 Pres 2 No 1 Indian,
Usual Residence of Decedent	1 Pres 2 No 17 Indian, C.
Baltimare Pikesville	Indian,
	Indian, c.
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 10g. Citizen of What Country 11g. Was Decedent Ever in U.S. 11g. Was Decedent Ever in U.S. 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- 11g. Was Decedent of Hispanic Origin? (Specify Yes or	ack
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nofixe, etc.) 14. Race - American ff Yes, specify Cuban, Mexican, Puerto Rican, etc.)	ack
10a. State 10b. County 10c. City, 1 own or Location 10d.	stry
Specify: Specify:	1 4
The property of the property o	Lare
Table 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 20. 5. K. G. C. 20. 5. K. G. 20.	-0
The second state of the se	ode) Z1Z08
Drendo Jones data they coas Kahn Dr. Kesvile. 20a. Method of Disposition 20b. Place of Disposition (Name of Date VNK 20c. Location - City or Town	n, State
20a. Method of Disposition Comparison C	MA
22. Name and Address of Facility	D18-134
shock or heart failure. List only one cause on each line	Approximate nterval Between
Physician Immediate Jause (Final disease or bondition resulting in death) a. End-Stay Restricted & disease or bondition a.	Onset and Death O Years
Examiner	
a if any, leading to constant Due to (or as a consequence of):	
pento ex legion by the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
de dicate be examinated as the burial as the	
So the policy of	y Day Year
d. Comparison of the part o	ay real
O S A T T D A Was an 24b, Were autops autops autops A prior to come autops A prior to come	sy findings available pletion of cause of
performed? death? 1 yes 2 1 No 1 yes 2 So Was case referred to medical examiner? Hospital:	P No
25. Was case referred to medical examiner? 1 Yes 2 No No No No No No No	
27. Manny of Death (Month, Day Year) 28b. Time of Injury at Work? 1 Valuatural 5 Pending (Month, Day Year) Injury M I Describe how injury occurred	
28a. Date of Injury of Inj	Route Number,
2 2 2 2 3 3 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	ted
29a. Certifier (Check only one) 29m Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date and place) and manner as stated.	the cause(s)
and manner stated. 29d. Date signed (Month, Deligned) 29d. Date signed (Month, Deligned) 29d. Date signed (Month, Deligned) 7 Rubble 19 4 4 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO TRABELLE MAREGREGOR, 700 W. 40 th STREET, BALTISTORE, FOD 21211	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Aparts 35. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00069 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:15PM Physician/ Jan Jordan 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Lanvale If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs **Funeral** Months Hours Min. Country) Director 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State 10b. County 2 should be filed within 72 hours after death with the Maryland thit and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f sho 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code nd Numbe Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify: Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 8. Mother's Name (First, Middle, Maiden Symame) Father's Name (First, Middle, Last, 2 ige 1 and 2 should be nt of Health and Men t: If item 27 is marke City or Town, State, Zip Cod 19a. Informant's Name/Relationship (Type, . Mailing Address (Street and Number or Rural Route Number, other Baltimore, 20b. Place of Disposition (Name of Date Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department of Important: If any injury or ō 11'Ce Signature of Funeral Service Licenses Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, rval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final al Ma Physician/ Muo cardi disease or condition Medical resulting in death) Due to (or as a consequence of): years **Examiner** enal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) eavs physician and the burial-transit 00 the Hospital or Attending Physician: The law requires that the death certificate be executed Due to or as a consequence of) resulting in death) Last Be Completed by Physician/Medical f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (2002)** use as been signed by the attending should be detached for use as IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has s certificate ha performed 2 No 2 N 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Yes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Natural 5 Pending work? Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral

> State Registrar

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

30 32. Registrar's Signature

DHMH 17 Rev 7/2009

StPau

2011

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Ann Jarkowiec January 2011 12:52 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 911 Emory Church Road Upperco If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M **XX** F Months Mar. IZ 73 ^{Year} 1937 Maryland **Director** 216-34-1900 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes XX No Maryland Carrol1 Upperco 10e. Street and Number 10g. Citizen of What Country?
United States
of America 10f. Zip Code ö "natural", or items 23a o Funeral 911 Emory Church Road 21155 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2XXMarried by Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White If Yes, Give Year or Dates 3 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Baltimore County I Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Public Schools Instructional Assistant Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked ot traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve and injury or other traumatic eve once. မ Joseph F. Woods Dorothy M. Sauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Jarkowiec (Husband) 911 Emory Church Road, Upperco, Maryland 21155 20a. Method of Disposition
1 ☐ Burial XXX Cremation 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan 6, All Faiths Crematory & charge & Chapel 3 Removal from State 2010 4 ☐ Donation 5 ☐ Øther Specify) Manchester, Maryland ignature of Funer Eckhardt Funeral Chapel, P.A. 22, Name and Address of Facility 11605 Reisterstown Road, Owings Mills, MD 21117 ht 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): executed as the burial-transi Cause (Disease or linjury and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 1 Lyes 2 Lygen 9 Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No page 2 s has certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Hospital 2 🖹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 잍 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 Natural (Month, Day, Year) iniury 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi The discovery report of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 11 032882 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cartin 114 Rob- + w2100 € 17 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15 AM 201 0 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street a Examiner 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Country) Maryland 1 X M 2 - F (Month, Day, Year) 08/08/1947 217-50-2305 Director 63 Usual Residence of Decedent 28a-f shov 10a, State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Harford Aberdeen 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 920 Walker Street 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ō þ 1 X Never Married 2 Married X Yes 2 ☐ No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural". 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Fork Lift Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Kornegan, Sr. Stella Rumsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 short of Health and fitem 27 is n Charles Rumsey / Brother 920 Walker Street, Aberdeen, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 01/05/2011 Hanover, Maryland 21. Signature of Fw eral Service Lic in see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ach line Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death by the ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **N**o Inpatient 2 မ ER/Outpatient 3 DOA this within 24 hours after deau...
To the Funeral Director: After this 27, Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident

Division of Vital Records.

State Registrar

Medical

Investigation 6 Could not be

determined

Certifying Nurse

4 Homicide

only on

29a. Certifier (Check

DHMH 17 Rev 7/2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

eted cause of death (Item 23a) (Type, Print)

3900 Registrar's Signature 1 🗌 Yes

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month Amar Kaur 2:10 A January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 10600 Barn Wood Lane Potomac Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** June 20 Year 1917 1 □ M 2 **K**) F Months Days Hours Pakistan Director 220-23-9595 93 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Tyes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10600 Barn Wood Lane 20854 India 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian Indian If Yes, Give "natural", 3 Midowed 4 Divorced Completed Year or Dates item 27 is marked other than "natur other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o 2 Ganga Ram Malan Kaur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gursewa S. Pabla/Son in law 10600 Barn Wood Lane, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Januar^{Date} cemetery crematory or other place)
West Arundel
Crematory 1

Burial 2

Cremation 3

Removal from State Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Donaldson Funeral Home & Crematory P.A.
1411 Annapolis Road, Odenton, Maryland 21113 M01386 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Atherosclerosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 1 No
9 Unknown for 5 Other (specify) Day Year Pregnant at time of death Month 4 ☐ Pregnant 9 ☐ Unknown ed by the a signed by details Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Upper Gastrointestinal Bleeding 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 K No After this certificate 1 ☐ Yes 2 🛛 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury XNatural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Ai completed filled in by the fu Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 06 2011

Coleman, M.D., 1355 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D37142

January 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1135 PM =MANUE(Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE AT NORTHWEST HOSPITAI RANDALLSTOWN BALTIMORE . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min 1 ★M 2 □ F 219-10-1703 84 0470771926 **Director** Usual Residence of Decedent show 10a. State with the Maryland ural", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 POMONA EAST, #403 21208 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 🙀 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify. "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) BUILDER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FREDA BROWN KALUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY KALUS / WIFE POMONA EAST, #403 BALTIMORE, MD 21208 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 1/5/2011 HAR SINAI CEMETERY 4 Donation 5 Other (Specify) OWINGS MILLS, MD . Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. iset and Geath Immediate Cause (Final Ph sician/ disease or condition resulting in death) 2000 Medical Due to (or as a consequence of). Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on. Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has becompleted filled in by the funeral director, page 2 s autopsy I Yes 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Watural injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check eted cause of death (Item 23a) (Type

Registrar

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		Registrar		Certifica	ate of	Death				Reg. No).		
Physicia Medical Exami		Decedent's Name (First, Middle,La David M. H						1	2. Date of Death Month Day Ye January 1, 2011				3. Time of Death 0654 hrs
		4a. Facility Name (if not institution, g		-	4	b. City, Town		of Death	bandary		c. County of	Death	
		Johns Hopkins Hospital 5. Social Security Number 6.9	17 Apr (1	! ! ! . !		Baltimore		0.411	lo 0			0 D: #	
Funeral Director		212-15-1261	Sex 7. Age (I	n yrs. last birtl 24	nday) Yrs.		Days Hour	er 24Hrs. Min.	1	-		Foreign	nplace (State or n Intry) MD
		Usual Residence of Decedent	2 1		115.	1			- unc	20,	1300		
C :		10a. State 10b. County		c. City, Town	or Locati	on							10d. Inside City Limits
77 land f sho	힏	MD Balti	more	Ess	sex								1 Yes 2 No
7572 e Maryland or 28a-f show s	Director	10e. Street and Number 829 South Wo	odlunn Po	5.c		10f. Zip Cod				10g. Cit	tizen of What		try?
f 757 death with the Maryland or items 23a or 28a-f shor must be notified at occe.	al	11. Marital Status	12. Was Decedent Eve		13 Was	S Decedent of	221	igin? / Sne	cify Yes or N	in-	USA L14 Bace -		an Indian, Black,
r item	Funeral	1 Never Married 2 Marrie				es, specify Cu					White,	etc.	
after	by F		If Yes, Give Year or Dates:		1	Yes 2X	No s <i>pecify</i>	:			Specify: W	hi	te
hours fortur	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)				t's Usual Occu ost of working				16b.	Kind of Busin	ness/In	dustry
36 thin 72 te.	Completed	12th	College (1-4 or 5+)	Di	isak	oled					Disa	bl	ed
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	S	17. Father's Name (First, Middle, Las							First, M iddle,				
2121; uld be fil Mental F marked	Be	John L. Kar		Lie					en B				
O € 5 3 €	욘	19a. Informant's Name/Relationship (Colleen Kappe		196		Address (SI							Zip Code) MD 21221
re, MC 1 and 2 sl Health an fitem 27		20a. Method of Disposition		20b. Place of	Disposi	tion (Name of	cemetery		Date		Location - C		
imore Pages 1: nent of H aot: If it		1 Burial 2 XCremation 3 4 Denation 5 Other Specif	_	Bayv	iew	erplace) Crema	atory	1/7	/11	E	Baltin	nor	e MD
Baltimore, MI permit. Pages 1 and 2.5 Department of Health a Important: If item 27		21. Signature of Funeral Service Lice	nser			ame and Addr		20	Q Mac	e A	lve. I	3al	to. MD
Physician	\dashv	23a. Part I. Enter the disease, or com	plications that caused the	death. Do not									21221 Approximate Interval
/Madical		failure. List only one cause on a	each line.										Between Onset and Death
£xaminer	- 1	or condition resulting in death)	Due to (or as a conseque										
	5	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):								-	
	틟	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque										
cecuted and ransit	n/Medical Examine	events resulting in death) Last		ence or).									
1. in	dica	X UNPENDED	AMENDED 23a	,27 per	r me	g913	3-16-1	l vt					_
8760, tificate bong physic	§	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of				. Пе			23	3d. Date of de	,	.,
30x 68 leath certif e attending for use as		past 12 months?	4 Pregnant at time		=	al death er (Specify)	3Ectopi	c pregnanc	;у		Month	Da	ay Year
Box he death c	Physicia	1 Yes 2 No 9 Unknow	9 Unknown						1 2				
Records, P.O. Box 6 The law requires that the death cer cate has been signed by the attendi page 2 should be detached for use	ā	Part II. Other significant conditions	contributing to death bu	t not resulting	in the ur	nderlying caus	e given in Pa	art I.		_			ne cause of death?
ds, equire	Completed		·				-		24a. Was				ppsy findings available
e law e has be ge 2 sh	g.								auto perfo	ormed?	dea	th?	mpletion of cause of
Vital Rec ysicino: The his certificate director, page		25. Was case referred to medical				26.Pla	ace of Death	(Check on	1 Yes	2 N	10 1	Yes	2 No
of Vital Records, og Physiciae: The law requir where this certificate has been some all director, page 2 should	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🖍 ER/Ou	tpatient	3 DOA	Other ₄	Nursing I	Home 5	Reside	ence 6 (Other:	
ion of Vital I tteodiog Physiciao: feath. tor: After this certifi the funeral director,		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. T	ime of In	` ' _	njury at Work		8d. Describe	how inj	jury occurred		
Division al or Atteodi rs after death. al Director: A	Sati	2 Accident Spending Investigat		A11			Yes 2						
Divi	Certification:	3 Suicide 6 Could not determine		- At nome, rar	m, street	, ractory, orno	e bullaing, et	ic. 26	or Town,		and Number o	or Rura	al Route Number, City
Division To the Hospital or Atteotwithin 24 hours after death within 24 hours after death To the Fuorral Director: completely filled in by the		29a. Certifier 1 Certifying Physic	clan: To the best of my kn										
To th withir To th compl	Medical	one) 2 Medical Examine 29b. Signature and title of certifier	er: On the basis of examina and manner stated.	ation and/or in	vestigatio		on, death oc	curred at ti	ne time, date				
	-	Marin I	1 10 00				C.M.E.				Date signed nuary 2, 20		n, ∪ay, rearj
6.4	-	30. Name and address of person who	completed cause of death	ı (Item 23a)		1							
4		Margarita Korell MD. A	ssistant Medical Ex		00 W.	Baltimore	Street, Ba	altimore,	MD 2122	23			
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's 8	Signature	Ba	als							
	_	I R E : /1 /8	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	S 100 V	T.H.								

ORIGINAL

OCME

Amend 20b, per Fh 5911 1/4/11 TT Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ANUARL Physician/ 12:55 PM Frederick Kinder, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ALTIHORE II JASHINGTOW 5. Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F 220-36-2599 Hours Country) 69 Director MD Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Examiner must be notified MD Glen Burnie Anne Arundel 1 Yes 2XXNo ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 115 Marley Neck Road 21060 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No , or 1 Never Married 2 Married Black, White, etc. þ 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced If Yes. Give Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 1 and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Police Officer Law Enforcement traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick W. Kinder, Sr. Dorothy Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. Ms. Jana Kinder / daughter 599 TJ Jackson Drive, Falling Waters, WV 25419 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2011 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 01/05/20104 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. ar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cau Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit Physician: The law requires that the death certificate be executed and that initiated events Due to (or resulting in death) Last as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year g Unknown g | Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 1 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this Director After thi Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 \(\sum \) Yes 2 \(\sum \) No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined within 24 hours a Medical Certifying Physiolant of the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On her passing examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus 29a. Certifier Assist of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Pre 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comeath (Item 23a) (Type, Print) PITCHIS m State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3602 CLARINTH ROAD, APT. 2F BALTIMORE N/A 7. Age (In yrs. last birthday, If Under 1 Year If Under Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣M 2 🗆 F Months 0 Hours Min 12/24/2010 NONE Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Ty Yes 2 No N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3602 CLARINTH ROAD, APT. 2F 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 ☐ Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NONE NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EITAN LAGHAIE RIVKA HAKAKIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EITAN LAGHAIE/FATHER 3602 CLARINTH ROAD, APT. 2F, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place GUDATH ISRAEL OF 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/05/2011 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. kett 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician astro disease or condition resulting in death) neen Medical Due (or as consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death Yes 2 ☐ No signed by the a 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? မ

Hospital or Attending Physician: The law requires that the death certificate be executed ισ τιπε runeral Director; After this certificate has been si completed filled in by the funeral director, page 2 should i within 24 hours after death.

To the Funeral Director, After this

ted			1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknow
Complet			24a. Was an autopsy gridings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	ıly one)
2	1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 Other (Specify)
tificate:	27. Manner of Death 1 KNatural 5 Pending 2 Accident Investigation	(Month, Day, Year) Injury work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
Certii	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)

1 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifing 29d. Date sign d (Month, Day, Year) 01/05

21208 Name and address of per completed cause of death (Item 23a) (Type, F Pourle eight 5 Ave

State Registrar

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Month 5:30 A M Beulah R Leppo Jan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster 9. Birthplace (State or Foreign Country) MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min 1 M 2 X F 220-26-5373 92 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Carroll 1 Yes 2 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1343 Old Manchester Rd. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 XWidowed 4 Divorced Year or Dates and Mental Hygiene. is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Restaurant Elementary/Seconday (0-12) College (1-4 or 5+) Cook Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Andrew Rhoten Sarah Berwager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 729 Longview Ave., Westminster, MD Anna Rae Barnhart-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/6/11 Westminster, MD Kriders Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature Funeral Service Licens 211 homas Z. 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se Physician disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 🗷 No After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) NE HOUSE မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certified (Check Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D0067468 e any address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER KED 2115 DRNARANG 955 Center 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			se Type or State o			ndelible In artment of I		-		gible.	
	•	For State Registrar		, , , , , , , , , , , , , , , , , , , ,		tificate of L		, ,	Reg. No. 2		00078
Physicia	n/	1. Decedent's Name (First, Middle	NASS	=U	•			2. Date of Dea	ith Day	Yea	3. Time of Death
Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, o	r Location of Deat	1 Var	4c Coun	ity of Death	7 5 7 "
		126 N. Hickory				Bel Air	r		Hari		
Funeral Director		5. Social Security Number 243-52-3657	6. Sex 1 😿 M 2 □ F	7. Age (In yrs. la 75		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h (1935	9. Birtl	hplace (State or Foreign intry) Ch Carolina
how how	7	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation					10d. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD Harf	ord		l Air						1 ☑ Yes 2 ☐ No
th the	al Di	10e. Street and Number		-		10f. Zip Code			10g. Citizen o		untry?
ath wi	nuel	126 N. Hickory		t. 29 dent Ever in U.S	S 13 V	21014 Vas Decedent of H	lispanic Origin? (S	necify Yes or No-	U.S.A.		doon ladion
fter de , or its amine	δ	1 🛮 Never Married 2 🗆 Marr	ied Armed For	rces? 2 🔀 No	1	Yes, specify Cuba	an, Mexican, Puer		Bi	ack, White	rican Indian, e, etc.
atural	eted	3 Widowed 4 Divorced	If Yes, Giv Year or Da nt's Education			lent's Usual Occup			Speci	WI	nite
in 72 h e. nan "n	Completed	(Specify only highe Elementary/Seconday (0-12)	st grade completed) College (1-	-4 or 5+)	(Give I	kind of work done (O NOT use retired)	during most of wo	rking	16b. Kind of	Business I	ndustry
ed with Hygien ther ther ther ther ther there	Be C	12 17. Father's Name (First, Middle, L			В	aker				kery	
l be file fental l rked o tic eve	70	Arthur	Massey				Rebecc	me (First, Middle, i a		me) levin	S
should and N is ma aumai		19a. Informant's Name/Relationsh	nip (Type, Print)	•	19b. Mailir	g Address (Street	and Number or Ru	ural Route Number	City or Town,	State, Zip	Code)
and 2 Health em 27 ther tr		Doris Fowler / 20a. Method of Disposition	Sister	20h E		. Hickory	y Ave.,				
Page 1 ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S		State C	emetery, cren	natory or other place ts Registr		Date 05/2011	Hanove		Town, State aryland
permit. F Departm Importa any injur		21. Signature of Funeral Service L	1	1212	*	. Name and Addre	-				4
ದರ್ವಹನ	Ц	230 Part 1 Fatarities diseases	<u></u>	accord the side at						over,	MD 21076
Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	niy one cause on ea	ch line.	n, Do not ente	er the mode of dylin	ig, such as cardia	or respiratory are	est,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	enaj			_	\rightarrow	
	er	Sequentially list conditions, if any, leading to immediate	b. — Punto (or as a consequ	ionas ofi:						
uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	S C	or as a consequ	defice off.						
iar iar		resulting in death) Last	Due to (or as a consequ	uence of):						
icate be physici s the bu	ledic		d								
eath certifica attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pregnanc	cv		23d, E	Date of deli	ivery
law requires that the death certificate be nas been signed by the attending physic e 2 should be detached for use as the bu	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of c		Other (specify)			N	/lonth	Day Year
requires that the de been signed by the should be detached	by Pr	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use cor	ntribute to	the cause of death?
equires sen sig ould b								1 □ \	∕es 2 □ No	3 🗆 Pr	obably 4 Unknown
has by	Completed							24a. Was a autop perfor	sy		opsy findings available completion of cause of
an: The la tificate ha tor, page	Be Co	25. Was case referred to medical				26. PI	lace of Death (Che	1 Tes			2 🗆 No
hysici his cer il direc	To B	examiner? 1 Yes 2 No		Inpatient 2 🗆	ER/Outpatier	_ Oth	or	lome N Resid	ence 6 Ot	ther (Speci	fy)
ding P th. After t funers	cate:	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investic	9	of injury h, Day, Year)	28b. Time of injury	28c. Injur work M 1 🗆		28d. Describe ho	ow injury occu	rred	
r Atter ter dea rector: by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho		eet, factory, office	- 100 2 2 110			ber or Rur	al Route Number,
pital o		29a. Certifier 1 Certifying					1-1	City or Town			
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page	Medical	(Check 27 Medical E	Physician: To the be xaminer: On the bas Nurse Practioner:	is of examination	and/or invest	igation, in my opinio	on, death occurred	at the time, date ar	nd place, and d	due to the c	ause(s) and manner stated.
To the Common Co		29b. Signature and title of certifier	NA	7.		29c. Licens	e number	77	29d. Date sign	_	_
		30. Name and address of person v	who completed caus	e of death (Item	23a) (Type P	rint)	128	10	Van	3	2011 0 NZI 061
		MACLO	BUB	MO	69	346	h. Ah	n Blo	·d5	wind	0 NZ1061
Stat Registra		31. Date filed (Month, Day, Year)	0011	egistrar's Signat	ture						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day A^M 2, 2011 2:39 January Douglas Hamilton Moore, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maple Ridge Group Home Assisted Living Montgomery Rockville 6. Sex 1 ★ M 2 ☐ F 8. Date of Birth (Month, Day, Year) January 30, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Days Months Hours 579-32-4380 84 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 X No Maryland Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9813 Connecticut Avenue 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Judge Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Hamilton Moore, Sr. Lillian Edith Hutton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shelley Moore Janashek /Daughter 21415 Ridgecroft Drive, Brookeville, Maryland 20833 Date 5, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "hedical Examinar is ust be notified at

al Hygiene.

h and Mental h

item 27 i

permit. Pages Department of I Important: If its any injury or o jo

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed and -trar physician a sthe burialanding puse as t atten for us signed by the a page or Attending

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760,

To the Hospitai State Registrar

1.49	4 ☐ Donation 5 ☐ Other (Specify)	Montgomery Cre	matorium, inc; 20]	II Betnesda,	Maryland
9	21. Signature of Funeral Service Licenses	Robe	me and Address of Facility rt A. Pumphrey Fune West Montgomery Ave	ral Home/Rockville, In nue, Rockville, Maryla	nc. and 20850-2805
	shock for heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do not enter the cause on each line. Stroke	e mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death Sudden
L	resulting in death) Sequentially list conditions.	Due to (or as a consequence of): Atrial Fibrillati	.on		Months
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
edical E	L _d .				
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy her (specify)	23d. Date of d Month	elivery Day Year
ed by Pł	Part II. Other significant conditions containing Hypertension	tributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 I	
Complet				performed? death?	autopsy findings available completion of cause of
To Be	Till Tes 2 (2) INO	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3		th <i>(Check</i> o <i>nly</i> one) ome 5	Assisted Decify)Living
ation:	27. Manner of Death 1 📉 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and Number or I City or Town, State)	Rural Route Number,
Medical Certification: To		ician: To the best of my knowledge, death oc ler: On the basis of examination and/or invest and manner stated.			
Σ	29b. Signature and title of certifier		29c. License number D32332	29d. Date signed (Mor	
				Julianty 5,	

Suresh K.

31. Date filed (M

9801 Georgia Avenue, #2-20, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Gupta, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MICLER Physician/ RVERA Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Tate Chesapeake Hospice House Anne <u>Linthicum</u> <u>Arundel</u> Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth g. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 🗷 F 10-07-1926 Country)
Maryland Director 213-22-1819 Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2820 Jessup Road 20794 United States Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates Specify: Specify: 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) United States 12 Budget Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Albert Bendix Jeannette Higdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph J. Miller, Sr. spouse 2820 Jessup Road Jessup, Maryland 20794 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 01-06-2011 Elkridge, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Will Erons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line, Immediate Cause (Final Ansa and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence vi Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and I be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital HUSPILL မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 10455 Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 0 6 20

441

DEFENSE

me and address of person who completed cause of death (Item 23a) (Type, Print)

EN

MM

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For 1 _ State	Plea				d / Depa	artment of H	Health ar	re All Copi nd Mental H		•	
		Registrar					Cer	tificate of L	Death		Reg. I	No. 201	1. 7000
Physicia Medic		1. Decedent's Name Lucille		, Last) r1ene		1	Mosley			2. Date of I Month Janua	[Day Year 2011	3. Time of Deat O
Examin		4a. Facility Name (if	not institution,	give street and	number)		-	4b. City, Town, o	r Location of [Death	4	4c. County of Dea	ath
		Casey Ho 5. Social Security No		-	1- 4	(1	and the last of the last	Rockvil		(Hro Lone e		Montgome	
Funeral Director		185-32-8	3485	6. Sex 1 ☐ M 2 ∑		ge (In yrs. 18	ast birthday) Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of E (Month,)	Birth Day, Year	1941 Pe	rthplace (State or Foreign ountry) nnsylvania
nd how at	5	Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo	cation					10d. Inside City Limits
faryla 3a-f s iffied	ect	ОН	Frank	lin		C	o1umbu	S					1X Yes 2 ☐ No
the Nor 24	<u> </u>	10e. Street and Nun						10f. Zip Code			10g. (Citizen of What C	ountry?
s 23a	Funeral Director	2594 Bt	ulen Av	enue				43207				USA	
death item ner n		11. Marital Status		Arme	Decedent d Forces?	Ever in U.S		Vas Decedent of H	lispanic Origin an, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Am Black, Whi	
after al", or xami	d by	1 Never Marri		If Yes	Yes 2 🗙 , Give	No No	1	☐ Yes 21 No	Specify:			Specify: B1	,
nours natura cal E	Completed	3 LA Widowed		Year t's Education	or Dates.	_	16a Deced	lent's Usual Occup	ation		166	Kind of Business	
n 72 l an "r Medi	ם	(Spe	cify only highe:	T .	eted) ge (1-4 or	5+)	(Give I	kind of work done o O NOT use retired)		f working	100.	. Killa of Basifies:	sindustry
l withi		12			90 (1 101	· · /	Admir	nistrativ	e Assi	stant	Ol	nio Stat	e University
e filed Ital Hy ed ott	To Be	17. Father's Name (F		ŕ						s Name (First, Midd	,		
uld bu	-		Spence							tie Mae H			
2 sho th and 27 is 1 traur		19a, Informant's Na								or Rural Route Num.			_
f Heal f Heal item		20a. Method of Disp	Mosley	– Son		20b. P	ace of Dispo	sition (Name of		Columbus,	$\overline{}$	io 4320 Location - City o	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 [4 🗌 Denation			from State	ှိ ြဋ္ဌနိုင်	emetery cren n Rést	matory or other place Memoria	ř ,	an.7,2011		leynoldsl	
permit. F Departm Importa any inju		21. Signature of Par			1	Liber						icy nords.	ourg, on
88 = 88		X los	mil	VIlla	un		5	Schoeding 360 E. L	er Fun ivings	eral Home	Col	lumbus,	ОН 43232
		23a. Part 1. Enter the shock, or hear	he disease, or or the failure. List or	complications t	hat cause on each lin	d the death	n. Do not ente	r the mode of dyin	g, such as car	rdiac or respiratory	arrest,		Approximate Interval Between
Physician/ Medical		Immediate Cause (I disease or condition resulting in death)		a. Mu.	ltip1	e Mye	loma						Onset and Death
Examiner		resulting in death,	1	Due	e to (or as	a consequ	ence of):						
	iner	Sequentially list con if any, leading to im	mediate	b. — Due	e to (or as	a consequ	ence of):						
be executed sician and burlal-transit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	injury	C.									6
be executed sician and burlal-transit	cal E	resulting in death) L		Due	e to (or as	a consequ	ence of):						
ate be ohysic the bi			`	d									
eath certificate b attending physia for use as the b	M/c	IF FEMALE: 23b. Was decedent	progpant	23c. If yes	, outcome	of pregnar	псу					20 d Data of de	15
eath c atter	iciar	in the past 12 n	months?	4 🗆 1	Pregnant a	2 🔲 Fetal at time of d		Ectopic pregnanc Other (specify)	у		. 3	23d. Date of de Month	Day Year
the di	Physician/Medi	g Unknown		g 📗	Unknown								
s that gned se det	by F	Part II. Other signifi	icant condition	ns contributing	to death b	out not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
equire	ted								_	_ 1	Yes	2 □ No 3 □ F	Probably 4 X Unknown
law re nas be	Completed by									24a. Wa	opsy	prior to	rtopsy findings available completion of cause of
: The cate to page										1 🗌 Ye	formed? 2 X	death? No 1 ☐ Ye	s 2 🛛 No
sician: The law certificate has t irector, page 2 s	m	25. Was case referre examiner? 1 ☐ Yes 2 🔀		Hospital:				_ Othe	or.	(Check only one)			XI 4
g Phy er this eral d	e: 10	27. Manner of Death		28a. C	Date of inju	iry	ER/Outpatien 28b. Time of	28c, Injury	4 ∟J Nursi ⁄at	ing Home 5 L Re-			cify) Hospice
ath. rr. Afte	ficat	1 X Natural 2 Accident	5 Pending Investig	ation	Month, Da	y, Year)	injury	M 1 🗆	? Yes 2 ☐ No	0	·	,	
r Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determin	28e. P		ury - At hor c. (Specify)		et, factory, office		28f. Location City or To			ıral Route Number,
ortal or art Direction			137										
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2	Medical Ex	caminer: On the	basis of e	examination	and/or investi	igation, in my opinic	n, death occur	ice, and due to the or rred at the time, date and place, and due to	and plac	ce, and due to the	cause(s) and manner stated.
To the Complete Compl		29b. Signature and t	itle of certifier	. 0				29c. License	number		29d. D	ate signed (Mont	h, Day, Year)
		P Q	bleer	UY	8			D37142			J	anuary 3	, 2011
51		30. Name and addre							Rd.	Rockville	. M.	D 20855	
Stat	е	31. Date filed (Month	Ray, Xear				· pa		,		- , 111		
Registra	ir	ال	THE U D	2011	en	0 0	. que	JCA -					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ meeker Month Year nthony 04:10AM January 201 Medical 4a. Facility Name (if not institution, give street and pumber) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hapkins Bayriew lare (enter Da Innore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
11-28-1940 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗽 M 2 🗆 F Hours **Director** 215-34-8084 70 28a-f show 10a. State traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Edgemere 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7540 Bay Front Road 21219 USA "natural", or items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ş 1 Never Married 2 X Married 1 ☐ Yes 2 ☐MNo If Yes, Give Maryland 21215-0036 72 hours after 1 ☐ Yes ¾☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) 8 Paramedic Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Unknown Enid Moseley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Mary Ellen Meeker - Wife 7540 Bay Front Road, Edgemere, MD 21219 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State injury (4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematorv 1-5-11 Glen BUrnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home any llow Spring Road, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Due to (or as a consequence of): Vascular disease or condition years Medical resulting in death) Examiner Cerebral Vascular Accident 9months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year the a page 2 should be detached 9 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 Hospital Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death.

I Director: After t 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) 5 Pending filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP aughn Kimberk JOHNS eg trar's Signature State Registrar

Please Type or Print in Black Indelible Ink Fnsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Mitcherling Month Carlisle Year 743 A 7011 Medical 01 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FranklinSquare Kasedale alti 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** . Sex 1 🗶 м 2 🗆 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth Month, Day, Ye Months Days Hours Min 92 218-14-6824 Director 1918 Jan. Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 XNo 10e. Street and Number 4216 Overton Avenue 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 United States items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 No WWII Black, White, etc. "natural", or Completed by 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N College (1-4 or 5+) Bethlehem Steel Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Mitcherling Edith Carter 19a. Informant's Name/Relationship (Type, Print)
Ronald Mitcherling/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Dunnett Court, Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Fork United Meth. Church Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) 2011 Fork, Maryland Signature of Funeral Service Licenses 22 Name and Address of Facility Evans Funeral 8800 Harford] Chapel & Cremation Services Rd. Parkville, MD 21234 2/a. P.rt f. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In mediate Cause (Final Physician/ diese or condition resulting in death) 90 3 Medical Due to (or s a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ☐ Yes ∠ ☐ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has autopsy performed?

Yes 2 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 1 No Other: ဂ္ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Output Description Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of p

31. Date filed (Month, Day, Year)

Juare

altimore

on who completed cause of death (Item 23a) (Type, Print)

2: Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Brenda Lee Malloy Month 04,2011 January 12:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore County Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕶 F Months Days Hours Min 352-44-7412 **July** 09,1951 **Director** 59 Livonia, Michigan Usual Residence of Decedent items 23a or 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard County Columbia 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 5482 Cedar Lane UnitA4 21044-1232 United States permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important! I firem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Howard County General Neonatal Intensive Care Unit Secretary Elementary/Seconday (0-12) 12 College (1-4 or 5+) Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Allen Benjamin Clayton Malloy Oreta Wanda Putman 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Amber Krieger Livesey 605 Gaines Street Central, South Carolina 29630-9267 20a. Method of Disposition 20b. Place of Disposition (Name of cation - City or Town, State (Harford County) 1 Burial 2 XCremation 3 Removal from State Wednesda Exars Fue al Carel and 4 Donation 5 Other (Specify) Jan. 05, 2011 Forest Hill, Maryland Cremetion Services, Inc. of Funeral Service Licensee Jeffrey L.Gir,Sr. 22. Name and Address of Facility Funeral and Cremation Center, P.A. Jair, L. Lic. #100677 2325 York Road Timonium, Maryland Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Anoxic enc disease or condition wreich Medical resulting in death) Examiner DODONOS an Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequenc of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year been signed by the should be detached 1 Yes 2 7 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 유 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) ë 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Certifica Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a

To the Funeral E

completed filled

2011 address of person who completed cause of death (Item 23a) (Type, Print) AADOV N. Charles W) 6701 31. Date filed (Month, strar's Signature State Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

(Check

29b. Signatu

d title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Director Director	3. Time of Death
Scale Security Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not institution, give street and number) As. Facility Name (If not	545 PM
Social Security Number G. Sex 10 m 2 m 2 m 3 m 3 m 4 m 2 m 3 m 4 m 3 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 3 m 4 m 4	ORE
State December 2 December 2 December 2 December 2 December 2 December 2 December 3 Decem	place (State or Foreign
TO BE State 10b. County 10c. City, Town or Location 10d. Zip Code 10g. Citizen of What County 10d. Zip Code 10d. Z	ÏNIA
Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe CATHLEEK DUDLEY (GRANDDAUGHTER) 20a. Method of Dysposition 1 Burial / 2 (Cremation 3 Removal from State or Complete State or Com	10d. Inside City Limits
Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe CATHLEEK DUDLEY (GRANDDAUGHTER) 20a. Method of Dysposition 1 Burial / 2 (Cremation 3 Removal from State or Complete State or Com	1 Yes 2 No
Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe CATHLEEK DUDLEY (GRANDDAUGHTER) 20a. Method of Dysposition 1 Burial / 2 (Cremation 3 Removal from State or Complete State or Com	
Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe CATHLEEK DUDLEY (GRANDDAUGHTER) 20a. Method of Dysposition 1 Burial / 2 (Cremation 3 Removal from State or Complete State or Com	
Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe CATHLEEK DUDLEY (GRANDDAUGHTER) 20a. Method of Dysposition 1 Burial / 2 (Cremation 3 Removal from State or Complete State or Com	ACK
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zigner of the part of t	dustry
TOHN TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zigner of the place) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zigner of the place) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zigner of the place) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zigner of the place) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zigner of the place) 20c. Location - City or Town, State, Zigner of Disposition (Name of cameler), Crematory or other place) 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) METRO CREMATORY 19c. Place of Disposition (Name of cameler), Crematory or other place) 19c. Place of Disposition (Name of cameler), Crematory or other place) 10c. Place of Disposition (Name of cameler), Crematory or other place) 10c. Place of Disposition (Name of cameler), Crematory or other	
Burial 2 Cremation 3 Removal from State	
Burial 2 Cremation 3 Removal from State	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hyputures Arthrescents Corona Omerica Tricks Due to (or as a consequence of):	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hyputures Arthrescents Corona Omerica Tricks Due to (or as a consequence of):	MARYLAND
Physician Medical Examiner	LAND 21217
/Medical Examiner Sequentially list conditions b.	Approximate Interval Between Onset and Death
Sequentially list conditions b.	ease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
Medical by physicia of as the but of the but	
Solution by the part of the past 12 months? 1	ery Day Year
G at the first term of the fir	
9 Unknown	
24a. Was an autopsy au	ppsy findings available mpletion of cause of
The second of th	2 No
A symmetry of Death State of Section 1 and Section 1 and Section 2 and Section 2 and Section 2 and Section 3 and S	·y)
25. Was case referred to medical examiner? 1	
City or Town, State)	ıl Route Number,
29a. Certifier 29a. C	tated. o the cause(s)
one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month,	
House Revolution \$19667 01-02-26	011
30. Name and address of prod who completed cause of death (Item 23a) (Type, Print) Himsel Cause 7310 2 this Hylway 508 Gen Borne, Manyland 21061	
State Registrar 31. Date filed (Month), Day, Year) A2. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Physician/ Walter Magness 2302 01 Ol 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimon NIA Traum enter 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) ocial Security Number Funeral Davs Hours (Month, Day, Yea Year) Maryland 1 ☑ M 2 ☐ F 1927 Director 184-22-1010 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b. County must be notified at Director 1 🗆 Yes 2 🎽 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 23a Funeral USA 21015 1502 South Tollgate Road ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates White "natural", Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene.
7 is marked other than "n College (1-4 or 5+) Elementary/Seconday (0-12) Plumbing Company Owner / Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Clara (unk) Pennington and 2 should be f William Harry Magness 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1502 South Tollgate Road, Bel Air, MD 21015 Ruth S. Magness / Wife f Health other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Page 1 cemetery, crematory or other place) Department of Important: If it any injury or o 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Mountain Christian Cem. 1-5-11 Joppa, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee. ²² Name and Address of Facility Home, P.A. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition reldero Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Fal days Sequentially list conditions, if any, leading to immediate causs. Linter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day ed by the a 9 Unknown Unknown P.O. | 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy Jas page 2 performed? Yes 2 certificate 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** director, examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Anpatient 2 ER/Outpatient 3 DOA မ this 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at funeral 27, Manner of Death Certificate: After work? 1 ☐ Yes 2 🛱 No 1 Natural 2 Accident 5 Pending wheelchair from 12/29/2010 0422 Investigation within 24 hours after death To the Funeral Director: / completed filled in by the f 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State)
1502 5. Tolgate Rd. Bel Arr Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide building, etc. (Specify) Air MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29c. License number 29b. Sign: ure and title of certifier -03-2011 erson who completed cause of death (Item 23a) (Type, Print) 30. Name Balhmore MD 21201 Paules1

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Day 02 Physician/ 2011 Cynthia Mathias 06:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health & Rehab Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 11 1947 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 😡 F 212-52-3725 Yrs. Director MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8103 Main Creek Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 🗆 Widowed 4 🗆 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Retail Grocery Manager event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Tracey Hazel Brandt other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a item 27 Murrell Mathias (spouse) 8103 Main Creek Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State Jan. 05 Maryland Veterans Cem 4 Donation 5 Other (Specify) Crownsville, Maryland 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ame and Address of Facility Stallings Funeral Home, P.7 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine consequence of): Due to (or as a To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as been signed by the attending physician and 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 🔀 No I ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide injury 5 Pending 2 🗆 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca Alen Burne MD21061 SW unoh Did 31. Date field (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2011 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 201^{Ye} 2:40 A Ervin Baer Ness $0\widetilde{4}$ Physician/ January Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Parkville 8018 Harris Avenue 8. Date of Birth (Month, Day, April 11 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Harrisburg, PA **Funeral** Months Days Hours **X** M 2 □ F 199-24-9180 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f shooten traumatic event, the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2X No Parkville Baltimore Maryland Citizen of What Country?
United States 10f. Zip Code 10e. Street and Number 21234 Funeral 8018 Harris Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black White, etc. 1 Never Married 2 X Married White ģ Specify: 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 Divorced 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Kitchen Sales Representative N/A 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mary B. Baer ည J. Lewis Ness, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 8018 Harris Avenue Parkville, Maryland 21234 (Spouse) Joyce E. Ness 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemeter, crematory or other place) Evans, Funeral Chapel Bel Air 20a. Method of Disposition Forest Hill, Maryland permit. Page 1 s
Department of H
Important: If ite January 2011 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee

22. Name and Address of Facility
Evans Funeral Chapel & Cre
8800 Harford Road Parkvil

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or higher failure. List only one cause on each line. 22. Name and Address of Facility Chapel & Cremation Services any inj 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in data) HEPATIC FAILURE Physician/ resulting in death) Medical MONTH RUCTIVE **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine OLANGIO CARCINOMA attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Day in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certificate: To 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death injury work 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Registrar

D16801

03 Franklin Square Drive Ste 2200 Baltimore, MD 21237

June MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend * State of Maryand / 2011 of Health and Mental Hygiene State Amend Item 25 per me, g911,01/12/2011dhb Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Celeste Celestine 3. Time of Death Day Physician/ Thomascine Omolola Month Year 2011 Medical Tanuary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Baltimore Townson Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Months Days 215-46-6245 64 09/30/1946 Yrs Director MD Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2828 Harford Road 21218 USA death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 XMarried filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes ZXNo Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stylist Self Employed 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Thomas Carroll Taylor Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code)
2828 Harford Road, Baltimore, MD 21218 Department of Health ar Important: If item 27 is any injury or other trauonce. Bayo R. omolola / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 1/6/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Juneral Service License Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ multi forma 64 oblustoma disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any leading to immodule cause. Enter Underlying Examiner Due to for as a consequence of s been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes ∠ 5 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 X Yes Hospital Other: မ Hogonco 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D6070635 NUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 chanes Suite 4105 Baltimere, MD 21207 Patel 2 va

DHMH 17 Rev 7/2009

State Registrar

13

32. Registrar's Signature

/Medical Examiner Division of Vital Records, P.O. Box 68760, attending p s been signed by the s should be detached has page 2

ending physician and use as the burial-trans this certificate funeral director, After the 1

Physician

/Medical

Examiner

Funeral

Director

28a-f show

5

items 23a

'natural", or

Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. Is marked other than

Item 27 |

permit. Pages 1 Department of H Important: If ite any Injury or ot

Physician

21215-0036

Baltimore, Maryland

event, the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

ပ

Examiner

or Attending Physician: The law requires that the death certificate be executed Director: filled in by To the Hospital or A within 24 hours after c completely

Physician/Medical Completed by 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D 69540 01/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wal Man

32. Registrar's Signature

Shah.

JAN

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

OFIGINAL

Rd Swite 203

2011.

Parkille

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Facility Name (If not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death corn Homes If Under 1 Year I If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) **Funeral** 9. Birthplace Foreign 1 □ M 2 🗹 88 Hours 20-926 Country) **Director** Yrs. 10a. State death with the Maryland 10b. County notified at 10c. City, Town or Location 10d. Inside Gity Limits Director 28a-f 1 Yes 2 No timore 10e. Street and Number ō ms 23a or must be r 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Divorced Completed ac Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working No. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me econday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) ၉ eq pinous Informant's Name/Relationship Department of Health or Important: If it 19b. Mailing Address (Street and Number or Rural Route Number KOOSEVE1-20a. Method of Disposition 20b. Place of Disposition (Name of ematory or other place) Burial 2 Cremation 3 Removal from State cemetery, q 4 Donation 5 Other (Specify) lawn . Signature of Funeral Service Mensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between erval Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last been signed by the attending physician and Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 24 hours after deatn.

• Funeral Director: After this certificate halted filled in by the funeral director, pag 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **2** No 1 Plnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ☑ Natural 5 Pending injury work? Accident Investigation Suicide
Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one)

DHMH 17 Rev 7/2009

State Registrar Name and address of person who com-

31. Date filed (Month, Day, Year,

of death (Item 23a) (Type, Print)

32. Registrar

medical

21202

nercu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	of Maryla	-	artment of H		Mental Hy	giene		20000
			State Registrar			Cei	tificate of L	Death		Reg. No.	and the second of the second o	00092
Phys	sicia	1/	1. Decedent's Name (First, Middle,	,		_			Date of De Month	Dav	Year	3. Time of Death
M	ledic	al	Jc 4a. Facility Name (if not institution,		<u>Marie</u>	Pru		- Leasting of Dag	JANUA1		2011	1:00 A M
Exa	amin	er	SAINT JOSEPH	_		TER	4b. City, Town, or	r Location of Dea OWSON	tn	1	y of Death TIMC	DF
Fund	eral			6. Sex		. last birthday)	If Under 1 Year	If Under 24 Hrs		th	9. Birthi	place (State or Foreign
Direc			289-26-3580	1 □ M 2 💢 F	84	Yrs.	Months Days	Hours Min	Sept. 2	8,1926_	Ind	ity) iana
pi wor	#	_	Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation					I 0d. Inside City Limits
arylar ia-fsl	flied	Director	M1 1 D-1+4			,,						1 ☐ Yes 2🌠 No
the M or 28	e not		Maryland Balti 10e. Street and Number	more		Towsor	10f. Zip Code			10g. Citizen of	What Cour	
with 1	nst b	Funeral	3 Southerly	Court, U	nit 302	2	2128	6		U.S.	Α.	
death	m l		11. Marital Status	12. Was Dece	edent Ever in l		Was Decedent of H	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)		ce - Americ ck, White,	
after after or	xamir	व	1 ☐ Never Married 2 ☐ Marri 3 ☐ XWidowed 4 ☐ Divorced	If Yes, Giv		1	1 ☐ Yes 2 🎇 No		,	Specif	,	
ours attura	calE	Completed	15. Deceden	Year or Dates t's Education	ates.	16a, Decer	dent's Usual Occup	ation		16b. Kind of E	Wh	ite
Z1Z15-0036 within 72 hours after giene. er than "natural", o	Medi	립	(Specify only highes Elementary/Seconday (0-12)			(Give	kind of work done o O NOT use retired)		orking	TOD. FAIR OF E	03111633 111	addit y
withii giene	t, the		12	- Conege (1		C1e	erical			Mfg. A	ir Br	akes
land be filed vental Hyg rked other	eveni	To Be	17. Father's Name (First, Middle, La						arne (First, Middle,		1	11
Uid be uid be marke	natic	-	George_	Louis	Lal			Lel		arie		edham
Maryland 2 should be filed th and Mental Hy 27 is marked oth	traur		19a. Informant's Name/Relationsh				ng Address (Street and Dulaney			r, City or Town, WSON,M		
f Heal	other	ı	Mary Rever 20a. Method of Disposition	Sister		. Place of Dispo	sition (Name of		Date IC	20c. Location		
mo Page nent o	ry or		1 X Burial 2 Cremation 4 Donation 5 Other (S)	3 XRemoval from pecify)		•	natory or other place. Cemeter	·	3-2011	Carliel	a Thorn	. Ohio
Baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any inju once.		21. Son ture of Funeral Service Li	censee	1 101		. Name and Addre	,				lome, Inc.
n 885	두 의	(1)	Tank to ta	pu		10	050 York		owson, M			
	Ŧ		23a. Part 1. Enter the disease, or o shock, or heart failure. List or	nly one cause on ea	ach line.	ath. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
Physici Med		×	Immediate Cause (Final disease or condition resulting in death)	SEPS							9/0	Onset and Death
Exami	_		resulting in deathy		(or as a conse JMONI <i>A</i>							
		ē	Sequentially list conditions, if any, leading to immediate	b. ———	(or as a conse							
nted d	ansit	Examiner	Cause (Disease or linjury that initiated events									
executed ian and	≃	<u> </u>	resulting in death) Last	Due to	(or as a conse	equence of):						
cate be executed physician and	the bu	dical	'	d								
ertifica	se as	ĕ	IF FEMALE:	23c. If yes, out	tcome of prea	nancy				004 D	ata af dalis	
death o	io lo	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 🗌 Live		etal death 3	Ectopic pregnand Other (specify)	су			ate of delive onth	ery Day Year
the de	ached	Physician/M	g Unknown	g 🗌 Unki	nown							
that the	e deta	اڇ	Part II. Other significant condition	J	leath but not r	esulting in the u	inderlying cause give	ven in Part I.				ne cause of death?
dS, quires en sig	g pine	ted	DEHYDRATION						1 🗆	Yes 2 X No	3 🗌 Pro	bably 4 🗆 Unknown
VITAI KECOLOS, nysician: The law requires lis certificate has been significate has been significant has been sign	S Sh	Completed by							24a. Was autoj	osv	prior to co	psy findings available mpletion of cause of
The cate h	, page	် ပ							perfo	rmed? 2 🔼 No	death? 1 🗌 Yes	2 🗆 No
ITal sician certifi	rector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			1-	ace of Death (Cheer:				
Physic refris	aral d	ا ة	27. Manner of Death	28a. Date	of injury	ER/Outpatier 28b. Time of	nt 3 LI DOA	4 ☐ Nursing	Home 5 Resident Resid	-)
on C	e tune	cat	1 XNatural 5 Pending 2 Accident Investig	, I	th, Day, Year)	injury	M 1 🗆	? Yes 2 ☐ No				
DIVISION OT tal or Attending Programmers after death.	by #	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e, Place	e of Injury - At ing, etc. (Spec		eet, factory, office		28f. Location (S		er or Rura	Route Number,
ital ours aff	lled in		N									
Hosp 24 ho Fune	eted 1	Medical	(Check 2 Medical Ex		sis of examinal	ion and/or inves	tigation, in my opinio	on, death occurred	at the time, date a	ind place, and di	e to the ca	use(s) and manner stated.
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function of the this certificate has been signed by the attending physician to the Function of the this certificate.	Idwoo	Σ	29b. Signature and fitle of certifier	Nurse Practioner:	AU REPORTURATION	THE THEOWINGS !	29c. License		खान वर्गाय वर्गास ग्रेट हो। इ.स.च्या	29d. Date signe		
)	Von)	D :	37254		1/5	2/11	
			30. Name and address of person w	ho completed caus	se of death (Ite	em 23a) (Type, F	Print)		· · · · · · · · · · · · · · · · · · ·	1		
	S STATE		BOON POH LIM	M.D.,	7601 Registrar's Sign	OSLER	DRIVE,	TOWSON	, MARYL	AND 21	204	
Rec	Stat gistra	e r	31. Date filed (Month, Day, Year) JAN 0 5 2	011 12	negistrar s Sigi	1. Sar	Kal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State			-		rtment of I tificate of L			0	0.1.1	00000
			Registrar 1. Decedent's Name (First	st, Middle, Las	t)		007	incate of t	Jean	2. Date of De			3. Time of Death
	Physicia Medic		Arnold Vin	ncent Pr	eston					Januar	y 3, 2	2011^{Year}	1:20 A M
	Examin		4a. Facility Name (if not in						r Location of Death	1		unty of Dea	
			2524 Stone 5. Social Security Number			e (In yrs. last	hirthday	Baltimo If Under 1 Year	re I If Under 24 Hrs.	8. Date of Bir		imore	
	Funeral Director		219-18-989	96 12	M 2 D F	84	Yrs.	Months Days	Hours Min.	May 12,		9. Bit	rthplace (State or Foreign Duntry) Maryland
	nd how at	٦٢	Usual Residence of Dece 10a. State 10b	edent o. County		10c. City,	Town or Loc	ation			_		10d. Inside City Limits
	faryla Ba-f s tified	ecto	MD Ba	altimore	_	Balt	imore						1 ☐ Yes 2 🏹 No
	the A	i Dii	10e. Street and Number	220211102		Bull		10f. Zip Code			10g. Citizen	of What Co	ountry?
	th with	Funeral Director	2524 Stone	e Mill I				21208			USA		
036	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 3 Widowed 4		12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S. No		las Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- o Rican, etc.)		Black, Whit	erican Indian, te, etc. nite
2-0	hour 'natur	olete	15. (Specify o	. Decedent's Econly highest gra	lucation	Ţ		ent's Usual Occup	ation during most of wor	king	16b. Kind o	of Business	Industry
2	hin 72 ne. than '	Completed	Elementary/Seconday		College (1-4 or 5		life. DC	NOT use retired)		King	F:		
0	ed wil Hygie other ent, tt	Be (12 17. Father's Name (First,	Middle, Last)	4		Inves	tment Ad	18. Mother's Nan	ne (First, Middle,	Finar		
<u>lan</u>	d be fil dental irked tic ev	ပ္	Vincent J.	Peciu.	lis				Anna Fra			,	
Maryland 21215-0036	2 should be file Ith and Mental 27 is marked c 1 traumatic eve		19a. Informant's Name/F	Relationship (Ty	pe, Print)			-	and Number or Rui				· _ ·
6, ≥	and 2: Health em 27 ther tr		Marilyn B.		on / wife	_			ll Road;				
nor	age 1 ant of 1 art. If its		20a. Method of Disposition	remation 3 🗆		cerr	netery, crem	ition (Name of atory or other place		Date /2011		,	r Town, State
Baltimore,	permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other to once.		4 ☐ Donation 5 ☐ 21. Signatur Funeral	4		HTTT		Name and Addre	orp. 1/4/ ss of Facility	/2011	Towsor		York Road
m	an)		> 1000	I Our	V				n Funeral				on, MD 21204
				ure. List only	ications that caused e cause on each line	the death. (Do not ente	the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
- ,	Prysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_	a. Due to (or as a			ADENO	CAZCINO	MA			Offset and Death
						consequen	nce of):						ľ
	Examiner	L	Sequentially list condition	200	b ————————————————————————————————————	a consequen	ice ot):						9 MONTHS
		miner	Sequentially list condition if any, leading to immediate the course. Enter Underlying	liate	b. Due to (or as a								9 MONTHS
		Examiner	if any, leading to immedi	liate	b. ———	a consequen	nce of):						9 MONTHS
00		lical Examiner	if any, leading to immedicates. Enter Underlying Cause (Disease or ilnjury that initiated events	liate	b. Due to (or as a	a consequen	nce of):		-				9 MONTHS
09/80	rate be executed physician and the burial-transit	edical	if any, leading to immedicates. Enter Underlying Cause (Disease or ilnjury that initiated events	Jiate Sy	b. Due to (or as a	a consequen a consequen	nce of):						9 MONTHS
89	certificate be executed nding physician and use as the burial-transit	edical	if any, leading to immediate. Error Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint the past 12 month.	nant hs?	b. Due to (or as a c. Due to (or as a d	a consequent a consequent of pregnanc; 2 Fetal d	nce of): y yeath 3	Ectopic pregnant	zy		23d.	Date of de Month	
89	certificate be executed nding physician and use as the burial-transit	edical	if any, leading to immed cause. Ertor Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregi	nant hs?	b. Due to (or as a d. Due to If yes, outcome of	a consequent a consequent of pregnanc; 2 Fetal d	nce of): y yeath 3	Ectopic pregnand Other (specify)	гу		23d.		Blivery
89	certificate be executed nding physician and use as the burial-transit	by Physician/Medical	if any, leading to immed cause. Error undershir g Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant	nant hs?	Due to (or as a d. Due to (or as a d. 23c. If yes, outcome of light of li	a consequent a consequent of pregnance 2 Fetal data time of dea	nce of): y leath 3 ath 5	Other (specify)			obacco use c	Month contribute to	blivery Day Year to the cause of death?
89	certificate be executed nding physician and use as the burial-transit	by Physician/Medical	if any, leading to immediate. Error undershir g Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 Nog Unknown	nant hs?	Due to (or as a d. Due to (or as a d. 23c. If yes, outcome of light of li	a consequent a consequent of pregnance 2 Fetal data time of dea	nce of): y leath 3 ath 5	Other (specify)		1 🗆	obacco use c	Month ontribute to	elivery Day Year o the cause of death? Probably 4 □ Unknown
89	certificate be executed nding physician and use as the burial-transit	by Physician/Medical	if any, leading to immed cause. Error undershir g Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant	nant hs?	Due to (or as a d. Due to (or as a d. 23c. If yes, outcome of light of li	a consequent a consequent of pregnance 2 Fetal data time of dea	nce of): y leath 3 ath 5	Other (specify)		1 24a. Was autor	obacco use c Yes 2 🕱 N an osy urmed?	ontribute to a lo 3 F	Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of
89	certificate be executed nding physician and use as the burial-transit	Completed by Physician/Medical	if any, leading to immed above. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 month 1	nant hs? t conditions co	Due to (or as a d	a consequent a consequent of pregnance 2 Fetal data time of dea	nce of): y leath 3 ath 5	Other (specify)	ven in Part I.	1 🗆 24a. Was autop perfo 1 🗆 Yes	obacco use c Yes 2 🕱 N an osy urmed?	ontribute to a lo 3 F	Day Year o the cause of death? Probably 4 □ Unknown
89	certificate be executed nding physician and use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immed audo. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 month 1	nant hs? t conditions co	Due to (or as a d	a consequent a consequent of pregnance 2 Fetal d time of deaut not resulting the consequent 2 EF	once of): y leath 3 lath 5 lath 5 lath 5 lath 10 lath	Other (specify)	ven in Part I. ace of Death (Checer:	1 ☐ 24a. Was autor perfc 1 ☐ Yes ck only one) ome 5 Resid	obacco use c Yes 2 🛪 N an sey rrmed? 2 🛪 No	Month ontribute to lo 3 F 4b. Were au prior to death? 1 Ye Other (Spec	elivery Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of ess 2 No
89	certificate be executed nding physician and use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immed audo. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 month 1	nant hs? It conditions contained a medical investigation	Due to (or as a c. Due to (or as a d. Due to (or as	a consequent a consequent a consequent 2 Fetal d time of dear ut not result in the consequent 2 EFTY, Year)	nce of): y leath 3 leath 5 le	Other (specify) 26. Pl 3 □ DOA Oth 28c. Injur work	ven in Part I. ace of Death (Checer: 4 Nursing H	24a. Was autoj perfor 1 U Yes ck only one) ome 5 Resid	obacco use c Yes 2 X N an 22 obsy rmed? 2 X No	Month ontribute to to 3	Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of second cause of second cause.
89	certificate be executed nding physician and use as the burial-transit	Certificate: To Be Completed by Physician/Medical	if any, leading to immed audo. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 month 1 wes 2 word No g with Unknown Part II. Other significant LYMP 25. Was case referred to examiner? 1 wes 2 No 27. Manner of Death 1 Natural 5 Accident 3 Suicide 6 Homicide	nant hs? t conditions co Ho MA medical Pending Investigation Could not be determined	Due to (or as a d	a consequent a consequent of pregnance 2 Fetal d time of death at time of	y eath 3 latth 5 ling in the ur	Other (specify)	ace of Death (Checer: 4 Nursing H y at y 2 Yes 2 No	24a. Was autor performent of the performent of the performent of the performance of the	obacco use c Yes 2 No an sy yemed? 2 No dence 6 0 0 ow injury occ street and Nu n, State)	Month ontribute to the contribute to the contri	Day Year o the cause of death? Probably 4 □ Unknown utopsy findings available completion of cause of es 2 □ No cify)
89	certificate be executed nding physician and use as the burial-transit	Certificate: To Be Completed by Physician/Medical	if any, leading to immed abuse. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preging the past 12 month 1 was 12 wo g with the last 12 month 1 was 2 wo g with the last 12 month 1 was 2 wo with the last 12 wo g with the last 12 wo g with the last 12 wo g with the last 12 wo with the last 12 w	nant hs? t conditions	Due to (or as a c. Due to (or as a d. Due to (or as	a consequent a consequent a consequent of pregnanc; 2 Fetal d time of deat time of deat ut not resulting the fetal and the fetal	ince of): y leath 3 leath 5 leath 6 l	Other (specify) 26. Pl 26. Pl 27. 3 DOA Other 28c. Injury work M 1 Det, factory, office	ven in Part I. ace of Death (Checer: 4 Nursing H y at ? Yes 2 No	24a. Was autop performed by the second of th	obacco use c Yes 2 N an an sy rrmed? 2 No dence 6 0 own injury occ street and Nu m, State) use(s) and ma and place, and	Month ontribute to the contribute to the contri	elivery Day Year of the cause of death? Probably 4 Unknown utopsy findings available completion of cause of its 2 No cify) ural Route Number, ated. cause(s) and manner stated.
89	rate be executed physician and the burial-transit	To Be Completed by Physician/Medical	if any, leading to immed abuse. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preging the past 12 month 1 was 12 wo g with the last 12 month 1 was 2 wo g with the last 12 month 1 was 2 wo with the last 12 wo g with the last 12 wo g with the last 12 wo g with the last 12 wo with the last 12 w	mant hs? t conditions	Due to (or as a c. Due to (or as	a consequent a consequent a consequent of pregnanc; 2 Fetal d time of deat time of deat ut not resulting the fetal and the fetal	ince of): y leath 3 leath 5 leath 6 l	Other (specify) 26. Pl 26. Pl 27. 3 DOA Other 28c. Injury work M 1 Det, factory, office	ven in Part I. ace of Death (Checer: 4 Nursing H y at ? Yes 2 No	24a. Was autop performed by the second of th	obacco use c Yes 2 N an an sy rrmed? 2 No dence 6 0 own injury occ street and Nu m, State) use(s) and ma and place, and	Month ontribute to to 3 Fab. Were au prior to death? 1 Ye Other (Specurred mber or Ru anner as stidue to the dimanner as stidue to the dimanne	Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of size 2 No cify) ural Route Number, ated. cause(s) and manner stated.
89	certificate be executed nding physician and use as the burial-transit	Certificate: To Be Completed by Physician/Medical	if any, leading to immed abuse. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preging the past 12 month 1 wes 2 worden No. Part II. Other significant LYMP 25. Was case referred to examiner? 1 wes 2 No. 27. Manner of Death 1 Natural 5 2 No. 27. Manner of Death 1 Natural 5 2 No. 28b. Signature and title of the control o	mant hs? It conditions condition	Due to (or as a d	a consequent a consequent a consequent 2 — Fetal d time of death at time o	ince of): y leath 3 leath 5 leath 5 leath 5 leath 5 leath 5 leath 3 leath 5 leath 5 leath 1 l	Other (specify) 26. Pl 26. Pl 28c. Injur Work M 1 = 29c. License Although 1	ven in Part I. ace of Death (Checer: 4 Nursing H y at ? Yes 2 No	24a. Was autor performance of the control of the co	obacco use c Yes 2 No an 24 ssy rmed? 2 No dence 6 0 0 sw injury occ street and Nu. m, State) use(s) and maind place, and e cause(s) and 29d. Date sig	Month ontribute to to 3 Fab. Were au prior to death? 1 Ye Other (Specurred mber or Ru anner as stidue to the dimanner as stidue to the dimanne	elivery Day Year o the cause of death? Probably 4 □ Unknown utopsy findings available completion of cause of size 2 □ No cify) ural Route Number, ated. cause(s) and manner stated. s stated.
89	certificate be executed nding physician and use as the burial-transit	Certificate: To Be Completed by Physician/Medical	if any, leading to immed abuse. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preging the past 12 month of the past 12 month	nant hs? It conditions condition	Due to (or as a c. Due to (or as	a consequent a consequent a consequent 2 Fetal d time of dear ut not resulting the fetal f	A/Outpatient Bb. Time of injury e, farm, streege, death ond/or investinowledge, death ond/or inv	Other (specify) 26. Pl 26. Pl 28c. Injur work M 28c. Injur bet, factory, office coured at the time gation, in my opinic eath occurred at the 29c. License MT 1 int)	ven in Part I. ace of Death (Checer: 4 Nursing H y at ? Yes 2 No , date and place, a on, death occurred a e time, date and place e number	24a. Was autop performed to the calculation (San City or Town and due to the calculation, and due to the calculation, and due to the calculation, and due to the calculation.	obacco use c Yes 2 N an sy 22 No dence 6 0 conow injury occ street and Nu nn, State) use(s) and ma and place, and e cause(s) anc 29d. Date sig	Month ontribute to the contribute to the course of the co	elivery Day Year of the cause of death? Probably 4 Unknown utopsy findings available completion of cause of security. In a Route Number, ated. cause(s) and manner stated. cause(s) and manner stated.
200	certificate be executed nding physician and use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical	if any, leading to immed abuse. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preging the past 12 month of the past 12 month	mant hs? It conditions condition	Due to (or as a d	a consequent a consequent a consequent 2 Fetal d time of death (Item 23) Fetal d time of death (Item 24) Fetal d t	ace of): y leath 3 leath 5 leath 5 leath 5 leath 5 leath 5 leath 3 leath 5 leath 5 leath 1 le	Other (specify) 26. Pl 26. Pl 27. 3 DCA Other 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 38c. Injury 48c. Injury 38c. Injury 48c. In	ven in Part I. ace of Death (Checker: 4 Nursing H y at ? Yes 2 No , date and place, a on, death occurred a e time, date and place e number	24a. Was autop performed to the calculation (San City or Town and due to the calculation, and due to the calculation, and due to the calculation, and due to the calculation.	obacco use c Yes 2 N an sy 22 No dence 6 0 conow injury occ street and Nu nn, State) use(s) and ma and place, and e cause(s) anc 29d. Date sig	Month Montribute to do 3	elivery Day Year of the cause of death? Probably 4 Unknown utopsy findings available completion of cause of security. In a Route Number, ated. cause(s) and manner stated. cause(s) and manner stated.

			For State Registrar	State of Mar		artment of l tificate of		Mental Hy	giene Reg. No.	Brightonia	00094
	Physicia		1. Decedent's Name (First, Middle, Las Fannie	Polyzois				2. Date of De	ath	Year	3. Time of Death 1:00 P M
*	Medi Examir		4a. Facility Name (if not institution, give			4b. City, Town, o	or Location of Dea		4c. County	of Death	
			Potomac Valley Nu				kville			gomer	
	Funeral Director			ex ☐ M 2 🖾 F 7. Age (H	n yrs. last birthday) Yrs.	If Under 1 Year Months Days			th 19, 17, 1921		ace (State or Foreign Ington, D.C.
	ind show at	٦	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	cation				10	d. Inside City Limits
	Aaryla 8a-f s tified	rect	Maryland Montgo	mery	Poto	omac					1 ☐ Yes 2 🛛 No
	the A	٥	10e. Street and Number			10f. Zip Code			10g. Citizen of V		•
	n with	Funeral Director	8716 Falls Chape	el Way			20854		United	State	s
ဖွ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 X No		f Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - America k, White, et	c.
903	ursaf :ural", al Exa	ted	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		I□Yes 2XINo	o Specify:		Specify:	Whi	te
15-(72 hou "nat ledica	ple	15. Decedent's E (Specify only highest gra		(Give I	tent's Usual Occup kind of work done	during most of wo	orking	16b. Kind of Bu	ısiness Indu	ustry
21215-0036	within / giene. ner thar t, the M	e Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+)	I	O NOT use retired, emaker	,		Own H	ome	
Maryland	be filed lental Hy rked ott	To Be	17. Father's Name (First, Middle, Last) John Varoutsos				1	ame (First, Middle, Papadop)	
ary	hould and M is mai		19a. Informant's Name/Relationship (7)	rpe, Print)				ural Route Numbe			
2	1 and 2 s of Health s item 27 i		Stephanie Polyzoi	s / Daughte	er 3001	Veazey T	errace,	NW #1317	, Washin	gton,	D.C. 2000
Baltimore,	Page 1 annuent of Hannuent of Hannuent if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	20b. Place of Dispo cemetery, cren Cedar Hil	natory or other pla		uary 5,	20c. Location - Suitlan	-	
Balti	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Privice License	mant	M01305 R0	Name and Address Dert A. Pu	ess of Facility Imphrey Fun It gomery Av	neral Home/ venue, Rock	Rockville	, Inc.	20850–2805
			23a. Part 1. Enter the disease, or comp shock, of heart failure. List only o	plications that caused the							Approximate Interval Between
H	Pnysician/	85 B	Immediate Cause (Final disease or condition		tion Pneu	monia					Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):						
	LXarriirici	ē	Sequentially list conditions,	b. Failur Due to (or as a co	e to Thri	ve				_	
	ed	Examiner	if any. leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	onsequence or):						
	xecut n and al-trar	Exa	that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):						
0	ate be executed physician and the burial-transit	edical		d							
68760	tificat ng ph	Mec	IF FEMALE:								
9 X	ath certifica attending p	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnan	су		23d. Dat Mor	e of deliver	y Day Year
Вох	e dea the a	ysic	in the past 12 months? 1 ☐ Yes 2 🎛 No 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	ne of death 5 L	Other (specify) _			Wioi	idi L	ay rear
P.O.	hat the led by t detach		Part II. Other significant conditions co	ontributing to death but r	not resulting in the u	nderlying cause gi	iven in Part I.	23e. Did to	obacco use contri	bute to the	cause of death?
S, I	uires tl n sign	Completed by	Dementia					1 🗆	Yes 2 🔀 No	3 🗌 Proba	ably 4 🗆 Unknown
orc	tw requires as been sig 2 should b	plet						24a. Was		Vere autops	sy findings available pletion of cause of
3ec	The larate ha	mo						autor perfo	rmed? d	eath?	
E	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?				lace of Death (Ch	<u></u>			
Ž	Physic this ce al dire	မ	1 ☐ Yes 2 🔼 No		2 ER/Outpatien		4 🔊 Nursing	Home 5 Resid			
n of	Jing F J. After 1 funera	ate	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yo	ear) 28b. Time of injury	28c. Injui	k?	28d. Describe h	now injury occurre	d	
Sio	Attence death	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		- At home, farm, stre		Yes 2 No	28f Location (5	Street and Numbe	r or Rural R	Youte Number
Division of Vital Records,	alor/s after s after al Dire		4 ☐ Homicide determined	building, etc. (S				City or Tou			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	(Check 2 L Medical Exami	ician: To the best of my ner: On the basis of exam	nination and/or invest	igation, in my opini	on, death occurred	d at the time, date a	ind place, and due	to the cause	e(s) and manner stated
	To the within 2 To the comple	Š	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the bes		death occurred at the 29c. Licens		place, and due to th	e cause(s) and mai 29d. Date signed		
	⊢≶Fő		> 257	$^{\prime}$ $>$ \wedge	(V)		062435		January		
			30. Name and address of person who co	ompleted cause of deat	n (Item 23a) (Type, P						
1			Sayed Elsayyad, M	.D. 10110	Molecular	Drive,	#206, Ro	ckville,	Mary1ar	nd 208	350
	Star Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature						

Alvin Anderson Parson

	1- For State Registrar		Cer	tificate of	Death			Re	g. No.			
Physician/	1. Decedent's Name (I	2. Date of Death Month Day Year January 1, 2011 3. Time of Death 0132 hrs							
Medical Examine		Anderson P not institution, give street and nu	arson		4b. City, Town, o	or Location		January 1	4c. County o	f Death		-
	Bon Secours		,		Baltimore				N			
Funeral Director	5. Social Security Nur 212-48-		7. Age (In yrs. la 63	st birthday) Yrs.	If Under 1 Ye Months Da				th(MM/DD/YYYY))4-47	9. Birth Foreign Cour	MD	
ı,	Usual Residence of D	Decedent Ob. County	10c City	Town or Locati	on						10d. Inside Ci	ity Limits
Maryland 28a-f show any d at once ector	MD	NA		ltimor	e				Og. Citizen of Wh		1 X Yes 2	-
the Maryland a or 28a-f sh tified at onco	10e. Street and Numb	_{er} Bentalou Str	eet		10f. Zip Code 2121	16		1	USA	at Count	y r	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatte event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married	1 2 Married Armed F	2 X No	If Y	s Decedent of H es, specify Cuba	an, Mexican	, Puerto Ri		White	, etc. A	an Indian, Bla frica	ick, Ti
rs after ural", niner	3 Widowed	4 Divorced If Yes, Give Yes or Dates: cation (Specify only highest grades)			Yes 2 X N	o specify: ation (Give		rk done	Specify: 16b. Kind of Bus		rican	
1215-0036 Id be filed within 72 hours afte fental Hygiene. sarked other than "natural", event, the Medical Examine or Be Completed by	Elementary/Second			during me	ost of working life	e. DO NOT			John Hospi	Hop!		
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical TO Be Comple	17. Father's Name (Fi			Tranc	porter	18.Mother	's Name (F	irst, Middle, N	Maiden Surname)			
21215 Mental H marked to count, to Be	Alvin	A. Parson,	Sr.	1.0			ary		longer	01.11	7: 0.4-1	
MD 21 3 2 should th and Me n 27 is ma numatic ev		e/Relationship (Type, Print) onger-Brothe	r						ber, City or Towr			133
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important! If item 27 is usignry or other traumatic.	20a. Method of Dispo-		20b. P				1		11stow 20c. Location -			
Baltimore, permit. Pages I an Department of Hea Important: If ited		Other Specify:	om State Ki	rematory or oth ng Meπ					Randa		·	
Balti Permit. Departn Import	21. Signature of Fune	eral Service Licenses			ame and Addre		y Wy:	lie Fu	ineral Baltim	Hom	e P.A	1217
Physician		disease, or complications that c	aused the death.								Approximate	Interval
/Medical Examiner	failure. List only Immediate Cause (Fir or condition resulting		ve Atheroscle		ovascular D	isease					Between Or Deat	
	Sequentially list cond if any, leading to imm	ditions, b	consequence of							-		
ted Insit Examine	cause. Enter Underly (Disease or injury tha	ying Cause at initiated	consequence of	<u>-</u>						_		
tecuted and transit	events resulting in de	d.										
5 ਫ਼ਿਜ਼ .≌	UNPENDED	AMENDED										
ox 68' eath certification is as in second for use as institution is a second in the se	23h Was decedent on	regnant in the 1 Live b	ant at time of dea	2 Fet	tal death 3 ner (Specify)	Ectopie	c pregnanc	Ey	23d. Date of o	delivery Da	y Y	'ear
P.O. B s that the d		cant conditions contributing to	death but not re	sulting in the u	nderlying cause	given in Pa	art I.		bacco use contrib	_		
cords, P law requires th has been signe 2 should be d						-		24a. Was a			ppsy findings	
Records, The law requires firete has been sig vage 2 should be Completed								autop perfor 1 Yes	med? de	nor to coreath?	mpletion of ca	ouse of
tal Recieins: The certificate rector, page	25. Was case referred	d to medical			26.Plac	ce of Death	(Check on		2 NO 1	V Tes	2] 140
f Vita Physicia or this ce ral direct To Bo	1 ✓ Yes 2	NO	Inpatient 2 🗹			Other ₄			Residence 6			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the stater death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated bertification: To Be Completed by P	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation	of Injury , Day,Year)	28b. Time of Ir		Yes 2		8d. Describe I	now injury occurre	id .		
Division of Hospital or Attending J 24 hours after death. Fuseral Director: After tely filled in by the funeral all Certification:	3 Suicide 4 Homicide		e of Injury - At ho	me, farm, stree	t, factory, office	building, et	tc. 21	8f. Location (S or Town, S	street and Numbe tate)	r or Rura	I Route Numb	per, City
To the Hospit within 24 bour To the Funerr completely fill		ertifying Physician: To the besidedical Examiner:On the basis and manner s	of examination an	e, death occur id/or investigat	red at the time, of ton, in my opinion	date and pla on, death oc	ace, and du curred at t	ue to the caus he time, date	e(s) and manner and place, and du	as stated ue to the	i. cause(s)	
E SES	29b Signature and tit					se number			29d. Date signe		h, Day, Year)	
	30 Name and addres	ss of person who completed cause MD. Assistant Medica			Itimore Stre	et, Baltin	nore, MI	D 21223				
State	31. Date filed (Month,		egistrar's Signatur									
Registra	1	JAN U 4 2011	annu !	B. 14	selled.							
DHMH 17 Rev 1/2001		OCME		ORIGINAL								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Martha 201 1257 Janvary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Centr Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Dec. 26, 1950 1 🗆 M 2 🕱 F Hours Country) 215-56-6605 MD 60 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dundalk MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 406 Stefan Court 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 X Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give Specify. 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical MVA 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Edna Simms Arvel Hargis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Stefan Court Balto. MD 21222 John Przybylski /husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 1/7/11 Balto. MD 4 Donation 5 Other (Specify) neral Service Licens 22. Name and Address of Facility 21. Sign 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ASCVO long Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or imjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death]Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by sign be (1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 2 🗌 No 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-006 1115 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore Muryland 21224 Pantle, 4940

HDHMH 17 Rev 7/2009

State

Registrar

Hardin

31. Date filed (Month, Day, Year)

JAN

Eastern

Registrar's Signatur

Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Yie Soon Park 2011 10:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 619 Budleigh Circle Timonium 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours March 7, 1931 215-78-0241 79 South Korea **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Timonium Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 21093 619 Budleigh Circle America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2 **XX**Vo Maryland 21215-0036 Korean 1 ☐ Yes 2XXNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Soo Kyum Jung Bang Hyun Jung 19a. Informant's Name/Relationship (Type, Print)
Mr. Tae Joon Park/ husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 619 Budleigh Circle Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 6, 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State bulanev valuev 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 2011 Memoria] Gardens F Feral Service Signature Pencerul Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Stro Physician/ disease or condition resulting in death) minut Medical Due to (or as a consequence of): Examiner pertension ears Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o a a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has k autopsy death?
1 Yes after death.

I Director: After this certificate he in by the funeral director, page P.oarthviti 2 No æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No. 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

30. Nartisand address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 DOUGLAS RAMEY 0. SR. January 2:47 а Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1132 Wharf Drive Pasadena Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗷 M 2 🗌 F Months Days Hours Mir April 17, 1947 Director 218-46-9705 63 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 🗌 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1132 Wharf Drive 21122 U.S.A. or items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Ex#miner Armed Forces?
1

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced White Specify: Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Antique Furniture Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Antique Restorer Restoration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Owen Ramey Rosalie Duva11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Ramey (Wife) 1132 Wharf Drive, Pasadena, Maryland 21122 item 2 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place)
Crownsville V A Cem. 1 Burial 2 Cremation 3 Removal from State Jan. 07, 2011 Crownsville, Marylnd 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ sease or condition resulting in death) DUCKO Medical Due to (or as a prequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an Were autopsy findings available prior to completion of cause of certificate has I autopsy performed? death? 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 oo Be 26. Place of Death (Check only one) Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Acciden 2 Acciden 3 Suicide 5 Pending in 24 hours the Funeral Director. Sold filled in by the fur Accident Investigation M 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 3 [29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) January 4. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Sridhar

31. Date filed (Month, Day, Year,

Atluri

5

32. Registrar's Signature

7310 Ritchie Highway, Glen Burnie, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 per FH G911 1/18/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01-02-2011 Robert Ripoli P^{M} 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) NY **Funeral** Months Days Hours Min. 0 7 Month, Day, Year, 0 7 - 1 4 - 1 9 4 7 1 🛛 M 2 🗆 F Director 63 Yrs 133-36-0454 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford 1 ☐ Yes 2 🔀 No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 S. Atwood Rd 21014 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 XXes 2 X No If Yes, Give Year or Dates. þ 1 ☐ Yes 2 🛣 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Ripoli Helen Yedlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ripoli (Wife) 110 S. Atwood Rd Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 01-06-2011 Baltimore, MD 21. Signature of Funeral Fervice Licensee 22. Name and Address of Facility Schimunek Funeral Inc 610 W. MacPhail Rd BelAir, MD Home of BelAir 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARG disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any lessing to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a detached for 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚨 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has le page 2 s autopsy his certificate h Il director, page perform 2 🗌 No 1 Yes Yes 25. Was case referred to medical on of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 ☐ Inpatient 2 € ER/Outpatient 3 ☐ DOA this 1 Natural 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 ho To the Fune completed fi (Check

State Registrar only one

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

JAN U 4

Gertifying Nurse Practioner: To the best of my knowledge, death continued at the line, date and place, and due to

who completed cause of death (Item 23a) (Type, Print) M.D.500

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:10 A M 01 201 Juanita Elaine Siegel /Medical 4c. County of Facility Name (If not institution, give street and number) Examiner Saltimore Rosedale HOS. quare If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number Funeral Hours Vear Days 1 □ M 2 🔀 F Months 8,1925 85 October 214-20-1192 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or than "natural", or items 23a or 28a-f show the Medical Exprimer rest be notified at 1 ☐ Yes 2 🙀 No Director Md. Balto, Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 USA 3028 California Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify. 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Food Warehouse other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard Pfeffer Jessie Patone ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Timonium, Md. 21093 402 Walpole Court Robert J. Pfeffer, Sr Bro. other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or ot once. t Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 1-7-2011 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final orgon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dementa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68769 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 140 3 Ectopic pregnancy signed by the atte 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 1 □ Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 atural 2 Accident 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0070076 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Kankanala MD Partuille mp-21234 2213 waltham unoon Ed, She 204,

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ " Month 10 AM NORMAN Medical W. SPONAUGLE 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4g/ County of Death ospita e 09 rase If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country)

V. VIRGINIA **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 🔀 M 2 🗆 F Months Hours Min. 79 0*5*%22%1931 Director 232 44 9977 Yrs Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 Tes 2X No 10e. Street and Number 10f. Zip Code r items 23a or iner must be r 10g. Citizen of What Country? Funeral 1315 SPRING AVE 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. injury or other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced 1949 Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7: f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 ELECTRICIAN BALTIMORE CITY Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RAYMOND SPONAUGLE MARGORE ALLMAN 19a. Informant's Name/Relationship (Type, Print) WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CASIMIRA MERCY SPONAUGLE 1315 SPRING AVE BALTIMORE, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 01/08/11 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown ed by the a signed h Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by been sic Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of his certificate has bil director, page 2 sf 24a. Was an autopsy performed Yes 2 No death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined n 24 hours after e Funeral Dire eleted filled in b City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o 29d, Date signed (Month, Dav. Year) 30. Name and address of herson who completed cause of death (Item 23a) (Type, Print) 9000 31. Date filed (Month, Day, Yes 32. Registrar's Signature State JAN 06 Registrar

Sponay

HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 Day Physician/ 20ÏI January 7:00 AM John Stigi Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11145 Willowbrook Drive Montgomery Potomac If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1949 **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F New York Yrs. Director 61 133-40-6395 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No <u>Maryland</u> Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11145 Willowbrook Drive 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married Yes 2 X No Yes, Give ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Federal Drug Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Administration Division Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Dominic Lewis Stigi</u> Assunta Susie Morgello ^{19a} Informant's Name/Relationship *(Type, Print* Katherine Stigi aka/ Bee Yong Ooi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 11145 Willowbrook Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium. Inc. ☐ Burial 2 X Cremation 3 ☐ Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda. 21. Signature of Funeral Service License R²² Name and Address of Facility Chase, Runeral Home, Chevy Chase, Hayon 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) l6 Months Multiple Myeloma Medical Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transit Cause (Disease or liftjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? certificate 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month. Day. Year) D29675 January 5, 2011

Registrar
DHMH 17 Rev 7/2009

State

Backs

6420 Rockledge Drive #4100, Bethesda, Maryland 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Ralph Boccia,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type o	Pri	nt in I	Black	Indelib	le Inl	k. Ens	ure A	All Copie	s Are	Legib	ole.		
		For		State	of M	arylan					and N	∕lental Hy	giene	100	9	00100)
		State Registrar				_	Ce	rtificat	e of L	Death		Τ΄	Reg. No	CUI	1	DUIUS)
Physicia	ın/	1. Decedent's Name		e, Last)	1	115	e)					2. Date of De Month	eath Da	у , \	ear,	3. Time of Death	. 4
Medic		4a. Facility Name (if	not institution	aive street and nu	mber)	IUS	OVU	4b City	Town or	r Location	of Death		JAN.	. County of	Dogth		VI
Examin	er	University	0 1/	A / A/ /	l So	nter		4B. ORY	Sal	timo	re		40.		Non		
Funeral		5. Social Security N		6. Sex 1 □ M 2 K F	7. Ag		ast birthday,	If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir	rth		9. Birth Cou	place (State or Foreig	
Director		252-45-9		1 LJ M 2 A J F		38	Yrs.	WOTHIS	Duyo	Tiours		December	28,19	972	000	"" Georgia	,
ind thow	'n	Usual Residence of 10a. State	10b. County			10c. City	y, Town or L	ocation								10d. Inside City Limits	5
Aaryla 8a-f s tified	rect	Maryland	Ann	e Arundel					Seve	rn					- 1	1 ☐ Yes 2 X N	10
a or 2 be no	Funeral Director	10e. Street and Nun	nber					10f. Zi	o Code				10g. Cit	izen of Wh	at Cou	ntry?	
h with	nera	1755 Vill	age Sq							2114				Unite	d S	tates	_
r deat r iten iner i		11. Marital Status1 Never Marr	ind o Mil Mar	12. Was Dec	orces?		5. 13	. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Or ın, Mexica	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		 Race - Black, 			
s afte ral", c Exam	ed by	3 Widowed		If You Ci	ve	No		1 🗆 Yes	2 X No	Specify	:			Specify:	Whi	te	
hour hatur dical	Completed	/Sne		nt's Education est grade completed	0			edent's Usu e kind of wo			at of work	ina	16b. K	ind of Busi	ness Ir	ndustry	_
hin 72 ne. than '	mo	Elementary/Sec		College (5+)	life.	DO NOT us	e retired)			-					
ed wit Hygie other	Be C	17. Father's Name (First, Middle,	2 (ast)			Lice	ensed	<u>Prac</u>			SE_ e (First, Middle,	Maiden :		ing	Home	_
2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	اما	William S									e Joy	, ,	maden	ourname)			
hould and M s mar umat		19a. Informant's Na		hip (Type, Print)			19b. Mai	ling Addres	s (Street a			al Route Numbe	er, City or	Town, Stat	te, Zip	Code)	_
nd 2 s ealth n 27 i ertra		Jamie F.	Mason/	Husband			1755	Villa	ge S	quare	e Cot	ırt, Se	vern	, Mar	y1a	nd 21144	
Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disp		3 Removal fron	State	20b. P	lace of Disp	osition (Na	me of other plac	e)		Date	20c. Lo	ocation - C	ity or T	own, State	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation	5 Other (Specify)			emator	У				2011	0de1	nton,	Ма	ryland	_
permit. Departri Importa any inju		21. Signature of Fu	neral Service	icensee	м	00672		22. Name a Onald	nd Addres	Fune	tyal I	Home &	Crema	atory	P	å ^A 21113	
				complications that	caused	the death								Hary		Approximate	
Physician/		Immediate Cause ((Final	only one cause on e	ach line	1	240	10	110	- 5	7	0-00				Interval Between Onset and Death	
Medical		disease or conditio resulting in death)	on	a. Due to	(or as	a consequ	ience of):	2	-/VT		110	early			+	(month	2
Examiner	<u>.</u>	Sequentially list co	nditions.	b. —-											_		
sit sit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlying	Due to	(or as	a consequ	ience of):										
executed ian and irial-transit	Еха	that initiated events resulting in death) I	s	c. Due to	(or as	a consequ	ence of):								+		_
be existian sician burial	Physician/Medical			L													
tificate ng phy as th	Med	IF FEMALE:		T													_
th cert ttendir or use	ian/	23b. Was decedent in the past 12 r			Birth	2 Feta	death 3			у			1	23d. Date		very Day Year	
e dea the a	ysic	1 Yes 2 9 Unknown	⊠ No	4 ☐ Preg 9 ☐ Unk		t time of d	leath 5	Other (s	pecify)					MOTH		Day Teal	
hat th ed by detac	y Ph	Part II. Other signif	icant condition	ons contributing to	death b	ut not res	ulting in the	underlying	cause giv	en in Part	l.	23e. Did t	tobacco u	se contribu	ute to t	he cause of death?	
uires l n sign uld be	Completed by	Ni	434									1 🗆	Yes 2	SAVO 3	☐ Pro	bably 4 🗆 Unknow	۷n
w required to the second to th	plet	141	RF									24a. Was				ppsy findings available	
The la ate ha	Som	,										perfo	ormed?		ath?	2 No	
cian; ertific ector,	Be	25. Was case referre		Hospital:						ace of Dea	ith (C <i>heci</i>	k only one)					_
Physi this c	<u>.</u> To	1 Yes 2	No	1 28a. Date			ER/Outpation		OA Othe	4 ∟ N		ome 5 Resi			Specif	y)	_
ding th. After fune	Certificate:	1 Natural 2 Accident	5 Pendir	ng (Mor		(Year)	injury	M	work		- 1	28d. Describe I	now injury	/ Occurred			
Atter ector by the	rtifi	3 Suicide 4 Homicide	6 Could	not be 28e. Place	of Inju	ry - At ho	me, farm, st	treet, factor	y, office						or Rura	l Route Number,	
ital or irs after al Dir						C. (Specify)						City or Tov					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the bu	Medical	(Check 2	🗀 Medical B		sis of e	xamination	n and/or inve	stigation, in	my opinia	on, death o	ccurred at	t the time, date a	and place,	, and due to	the ca	ause(s) and manner sta	ated
o the vithin 2 or the omple	ž	only one) 3 29b. Signature and		Nurse Practioner:	To the	best of my	knowledge		rred at the		e and plac	e, and due to th		and mann te signed (//			_
FSFö		1	1	7/ N	10				13160	1104	155					2011	
20		30. Name and addre	ess of person	who completed cau	se of d	eath (Item	23a) (Type,	Print)	0/ 3	110	7 1	ilhore, M			1 0		
3		Thias		audar	2	3 P.	erside	Drive	#41	1, `	Balt	thore, M	2	1230			_
Stat		31. Date filed (Monti	h, Day, Year)	32. F	Registra	ar's Signat		S. C.		,		-					

11-00115 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David William Savage State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** January 4, 2011 David William Savage 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Franklin Square Hospital Center **Baltimore County** Rosedale If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Director 219-86-9025 1 X M 2 F 34 February 21,1976 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County "natural", or items 23a or 28a-f show Baltimore Maryland Essex altimore, MD 21215-0036

mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryl epartment of Health and Mental Hygiene.

aportant: I fitem 71 is marked other than "natural", or items 23a or 28s-f inportant: Hor or other traumatic event, the Medical Examiner must be notified at o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 401 Mace Avenue 21221 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 X Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunication Radio Front Line 12 years 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lonnie Ellis Savage Adela Janicki 19a. Informant's Name/Relationship (Type, Print) Kimberly Rose Savage Sister 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition January Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10., 2011 Sacred Heart of Jesus Cem. 4 Donation 5 Other Specify Signature of Funeral Service Licensee Part I. Enter the disease, a complication failure. List only one cause on each line **Physician** /Medical Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit The law requires that the death certificate be executed Sa X UNPENDED AMENDED 23a, 27, 28a-f per me g911 1-28-11 vt Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Completed peen 24a Was an autopsy certificate has page 2: performe ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica director, Be examiner? ✓ Yes 2 No funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Natural 5 Pending 1 Yes 2 X No ţ d 1-4-11 Ed 6:58 am unknown Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8514 Sandy Plains Road, Dundalk, Maryland 20c. Location - City or Town, State Dundalk, Maryland Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. complications that caused the de in. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Combined Drug (Morphine, Oxycodone and Alprazolam) Between Onset and Death Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours asker death. To the Funeral Director After this certifi Other Nursing Home 5 Residence 6 Other 28d. Describe how injury occurred Certification: filled in by 28f. Location (Street and Number or Rural Route Number, City 401 Mace Ave. #B (Specify) house Essex, Md. Homicide 29a. Certifier 1 (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 5, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. 32. Registrar's Signature 0.6 2011 State arker Registrar OCME DHMH 17 Rev 1/2001 **ORIGINAL** OCME 2006

0740 hrs

Country) Maryland

USA

White, etc.

10d. Inside City Limits

1 Yes 2 X No

Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year hm. vanuari 700 Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3 towar 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of 20 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Months Days Hours Min Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 ☐ No MO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1040 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 17,9 siness Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ပ hmi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code Edge fath 21044 20a. Method of Disposition Location - City or Town, State 20b. Place of Disposition (Name of 20c ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 2011 ☐ Donation 5 ☐ Other (Specify) umbia . Signature of Funeral Service Lice Fune ton 11000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or wart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician/ nous Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has autopsy performed Yes 2 death? After this certificate 1 Yes 2 10 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 1 🛄 Yes 2 🗌 No 24 hours after deat Funeral Director. 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 the only one) within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5 2211 Munava 2 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trus Wimone, MD 33 31. Date filed (Month, Day, Year) State JAN 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 04:55 A M Dorothy E. Sponsel 04 ANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON JOSEPH MEDICAL CENTER SAINT 8. Date of Birth (Month, Day, Year) May 3 1920 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 24 Hrs Funeral Months Days Hours Washington DC 1 - M 2 X F 90 Director 219-01-9642 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No Towson Baltimore Md. ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21286 #111 800 Southerly Rd. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify: If Yes Give White Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be nent of Health and Menta Ethel Tucker Joseph Uhlfelder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1590 Rossanne Pl. Englewood, Fl. 34223 Department of Health a Important: If item 27 i Mrs. Virginia Van Atta/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Dremation 3 Removal from State injury or Towson, Md. 4 Donation 5 Other (Specify) Hilltop Service Co. 1-5-11 22. Name and Address of Facility Ruck Towson Funeral Home, Signature of Furieral Service Lic Towson, Md. 1050 York Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION Physician/ HOUR disease or condition Medical resulting in death) Examiner 10 MWATES RESPIRATORY FAILURE Sequentially list conditions, Examine Due to for as a consequence of il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury COLL APSE Hospital or Attending Physician: The law requires that the death certificate be executed CARDIOVASCULAR and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown the s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASCULAR DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 🗋 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify 2 No ER/Outpatient 3 DOA 1 Yes 1 Inpatient 2 မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending a Hospinston 24 hours after death.

The Funeral Director; After a by the further and the furth 1 Yes 2 🗌 No Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 6 2756

State Registrar 7601 OSLER DRIVE

TOWSON MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

TAMARAINTNER

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per SVR g911/0//2011 JH. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 2011 Year Frank Nicholas Smith, Jr. January 4:42 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 16, I **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Hours Min Virginia Director 219-46-9077 63 Ĭ947 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14405 Jericho Park Road 20715 U.S.A. death \ 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever III 0.5.
Armed Forces?
1 ▼ Yes 2 □ No
If Yes, Give
Year or Dates. 1966-70 þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 X Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) 5+ Artist Art Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Nicholas Smith, Sr. Margaret Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Diane Sweeney /executrix 12712 Buckingham Drive, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Jan 4, 11 Odenton, Maryland Signal re of Funeral Service Licen 22 Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 DWH M00773 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ Lnterstitio disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner month umon Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed erna tuis Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day 2 No signed by the 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an Director: After this certificate has autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? Investigation 1 Yes 2 No Accider
Suicide Accident 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my polinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) oleTD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Schepleng, II	1	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2011	00108
Physician Medical Examine	1	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vers	ne of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 326 Torner Road 4c. County of Death Essex Baltimore County	
Funeral Director		5. Social Security Number 212-04-0181 6. Sex 17. Age (In yrs. last birthday) 43 Yrs. 6. Sex 17. Age (In yrs. last birthday) 43 Yrs. 6. Sex 18. Date of Birth (MM/DD/YYYY) 9. Birthplace Months Days Hours Min. Nov. 30, 1967 Foreign Country)	(State or MD
and show any ncc.	ľ	MD Deltimone	nside City Limits
1 the Maryland 3a or 28a-f sh otified at onco		10e. Street and Number 326 Torner Road 10f. Zip Code 21221 USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impurtant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury mr other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	⋧┞	11. Marital Status 1 Never Married 2 Married 2 Modern Signature 1 Note of Process 2	9
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan		Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Constructi	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middle, Last) John Allen Schepleng Jr. 18. Mother's Name (First, Middle, Maiden Surname) Deanna Minda Johnson	
MD 21 nd 2 should alth and Me m 27 is ma	L	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: 20c. Location - City or Town, Specify and Address of Earlity 20c. Location - City or Town, Specify and Address of Earlity 20c. Location - City or Town, Specify and Address of Earlity 20c. Location - City or Town, Specify and Address of Earlity 20c. Location - City or Town, Specify and Address of Earlity	
Physician Physician	- 1		1203 oximate Interval
/Medical Examiner	1		veen Onset and Death
ne l	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
0, be executed sician and burial - transit		Closease or injury that mindled events resulting in death). Last Due to (or as a consequence of): d.	_
0,0,e be exect ysician an burial - tr		UNPENDED AMENDED	
Division of Vital Records, P.O. Box 68760, the Boopital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Directur: After this certificate has been signed by the attending physician and nipletely filled in by the funeral director, page 2 should be detached for use as the burial - transit slical Certification: To Be Completed by Physician/Medical Ex		FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Year
res that the signed by the detache	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the raster death. 1 Directur: After this certificate has been signed by led in by the funeral director, page 2 should be deach sertification: To Be Completed by P		24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	
Vital ysician: this certification director	2	25. Was case referred to medical examiner? 1	
ion of Vi ttending Physi leath. ttur: After this / the funeral di		27. Manner of Death 1 Natural 5 Pending Investigation Investigation Processing Section 1, 2011 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 No Shot self 28d. Describe how injury occurred Shot self	
Division o Bospital or Attending 24 hours after death. Funeral Directur: After filled in by the funeral or the	3	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) (Specify) Other (specify):outside 326 Torner Road, Essex, MD	∋ Number, City
To the Ho within 24 F To the Fu completely	0	Check only Check only Medical Examiner: 10 the best of my Knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated.	s)
2	2	99b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, January 2, 2011	Year)
5	3	0. Name and address of persoyl who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	-	1. Date filed (Month, Day, Year) 32. Registrar's Signature	
DHMH 17 Rev 1/2001		ORIGINAL OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 AM Marvin F. Silver, Sr. 10:40 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days July 12, 1 **X**) M 2 □ F Months Hours 220-20-0489 85 Maryland Director Usual Residence of Decedent show 10d. Inside City Limits 10h County 10c. City. Town or Location with the Maryland at 10a. State Director ems 23a or 28a-f sh must be notified a Baltimore MD Baltimore 1 Yes 2 No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21206 8 Maple Avenue United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Examiner Black, White, etc. ori by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify. White "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police 12 Clerk Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Benjamin Silver Mary Wolf traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Carroll - Daughter 23 Pine Chip Court, Nottingham, Maryland 21236 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once, ☐ Burial 2XXCremation 3 ☐ Removal from State Evans Funeral Chapel and Forest Hill, Maryland Jan. 6, 2011 4 Donation 5 Other (Specify) Cremation Services—Relair . Signature of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel and Cremation Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one car Onset and Death Immediate Cause (Final disease or condition Ph.sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequen Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) ____ ξ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy death? 2 🗌 No Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural М death. Accident Suicide Investigation after death Director: A d in by the f 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined rlo.
in 24 hours
io the Funeral Dicompleted fille Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 To the P 1500 a . Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Alfreda Constance January :40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 929 Middle River Road <u>Middle River</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Days Hours Min. (Month, Day, Yea 198 18 7538 88 **Director** June Pennsylvania Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 929 Middle River Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 X Widowed 4 ☐ Divorced White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Enoch Boris Smelak Constance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence W. Stetz (son) 520 Munroe Circle Glen Burnie Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 nonation 5 Other (Specify) Holly Hill Mem Gardens 1/4/2011 Baltimore County, Md of Funeral Service License 21. Signa 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex MAryland 21221 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pa Approximate Interval Between heart failure. List only one cause on each line APRES T Immediat use (Final Onset and Death Physician/ ARDIAC disease or conditi resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine ause. Enter Underlying the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 $ot\!f$ Residence 6 \square Other (Specify) Hospital: 2 🗷 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Records, P.O. completed filled in by the funeral director, page 2 should be det **Division of Vital** s after death 24 hours a

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 11 Wan CRUPT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1245 Eastern Blad ESSEXMD 2122/ SARAMSULLIVAN

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

State Registrar

Investigation 6 Could not be

determined

2 Accident
3 Suicide

29a. Certifier

(Check

32. Registrar's Signature ave

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month J/t/ Physician/ 01:39 AM 2011 Taylor Vietta Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore Hos Ital Baltimore 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2**X**□ F Months Days Hours Min (Month, Day, Year) 5-17-1929 Country) MD Director 24 - 0208Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland **Funeral Director** 1 Yes 2 □ No Baltimore MD na 10e. Street and Number 4019 Oswego Court 10f. Zip Code 10g. Citizen of What Country? 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". ~ any injury or other traumatic event. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Completed 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodiar 10th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Gertrude Thomas Augustus Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, MD 21215 Shawan Makel-Daughter 2652 Oswego Avenue 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State 1-11-2011 Balto, MD Greenmount 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March East F/H 15 21202 1101 E. North Avenue MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STRUKE Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): 20 years Examiner PERTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury that initiated events executed the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Respiratory autopsy death? 1 Yes 2 No this certificate Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury 1 Natural 5 Pending Investigation 2 Accident

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 after death. Director: After

To the Hospital o within 24 hours af To the Funeral Di Mu

Medical

Suicide

4 Homicide

Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number pliran H. WOLDEHINOT D0063327 Jan, 03, 2011

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

GIZAW WOLD EHOWOT, MD. 2434 W-BELVEDERE AVE, BACTIMORE, MD

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 201^{Year} Physician/ 10:40PM Melva Ruth Turpin January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing & Rehab Center Montgomery Olney 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In vrs. last birthday) Funeral Days (Month, Day, Year) Months Hours Min. Minnesota 1 🗆 M 2 💢 F 472-05-9397 Mav **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20905 14901 Donna Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married "natural", or þ 2 💢 No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical lonce. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Maude Conklin Frank Pettit 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 14901 Donna Drive Silver Spring, Maryland 20905 Toby Turpin, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 01/03/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE ONGESTIVE Physician/ disease or condition resulting in death) Medical HNEMA **Examiner** Sequentially list conditions Examine of any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury UEIN HEMORRHAGE MISCLAVIAN or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) ____ Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant
9 Unknown Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MELLITUS DIATSETES 1 Tyes 2 X No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No page 2 s To the Funeral Director; After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Natural 5 Pending 1 Yes 2 No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3370C Name and address of person who completed cause of death (Item 23a) (Type, Print) WILL AMSTORT 154 N. ARTICAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 011 Year Jan 1 3:45р м Physician/ Herman E. Travers Jr. Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Gilchrist Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number **Funeral** Month, Day, Year) March22 1**X** M 2 □ F 216-16-9823 85 Director Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director PArkville MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21234 USA 9734 Denrob Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 9 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: White If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Regional Scanning Manager A&P Food 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Amos McDonald Page 1 and 2 should be 1 Herman E. Travers Sr. 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Monocacy Road Balto. MD 21221 Herman Travers III /son Important: If item 2, and any injury or other ** Baltimore, 1 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 1/1/6/11 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Si 🛪 at. of Finaral Service Licens e Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lemento Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death detached 9 Unknown 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 3 Probably 4 □ Unknown 1 Yes 2 No COmmetive Demoron should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has performed Yes 2 CORRESAUCE hoort failur 2 🗀 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 24 hours after death. Funeral Director: A Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Extraction of the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) WITH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2011 MARKEN Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fern M. Vosseler ,201¹1 January 3:23 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) March 6, 1919 Birthplace (State or Foreign Country)
 Maryland If Under 24 Hrs. Hours Min. **Funeral** Months 1 □ M 2 🛛 F 91 219-14-9932 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Manktan Baltimore 1 Yes 2XX No MD10f. Zip Code 10g, Citizen of What Country? ь 10e Street and Number Funeral 21111 United States items 23a 1106 Blue Mount Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Paltimore County Schools Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve 2 Martha Wisner Harry Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jan Taylor - Daughter 1110 Blue Mount Road, Monkton, Maryland 21111 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date First Baptist Church Parkton, Maryland Jan. 7, 2011 4 ☐ Donation 5 ☐ Other (Specify) Hereford Cenetery Signature of Funeral Service Lice 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services - Monkton
16924 York Road, Markton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TER CORONARY Physician/ OYEAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate has 1 Yes 2 No Yes 2 ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 5 Pending 1 Watural work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed : (Check 3 🗌 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

100

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01-05-2011 Physician/ 1226 A Norma B. Watkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Rel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Country) 1 □ M 2 🗓 F 0 2 Day 920 MD 90 Director 220-09-4282 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21009 3607 Long Ridge Ct Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 1 ☐ Yes 2 👿 No Specify. Specify: White 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ೭ Florence Barnes Clarence Elroy Parsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Forest Hill, MD 21050 1614 Creston Dr f Health a Edward C. Watkins, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entonement Parkwood Mausoleum 01-08-2011 Parkville, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami Cause (Disease or iinjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA ပ this thin 24 hours after deam.

o the Funeral Director: After thin 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending injury work? Accident 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital ledical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basic of exemination and/or inventioning in the control of the cause of exemination and/or inventioning in the cause of exemination and or invention and or inve 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 01 201^{Year} Physician/ 2:39 Alvin P. Wyatt Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 08 25 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F DC Director 08 1936 579-46-5573 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director DC 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20009 USA 2101 New Hampshire Ave. NW #804 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black If Yes, Give "natural", Completed 3 - Widowed 4 Divorced Year or Dates event, the Medical 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) be filed within Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Rebecca Carter traumatic Julius F. Wyatt, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health 2101 New Hampshire Ave. NW #804 Washington,DC 20009 Department of Health Important: If item 27 any injury or other tr Rosemary C. Wyatt/Sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Page 1 1 Burial 2 X Cremation 3 Removal from State 01/05/2011 Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. 22. Name and Address of Facility Marshall-March Funeral Home 21. Signartive of Funeral Service License 4217 9th St. NW Washington, DC 20011 molelon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTEMYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** GASTRO INTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Yes signed by the a g Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
24 hours after death.
Pinerotor: After this certificate has been signed by it red filled in by the funeral director, page 2 should be debached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPURTEUSIM 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EMPHYSEMA autopsy performed 1 ☐ Yes 2X No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DONE D403>4 ddress of person who completed cause of death (Item 23a) (Type, Print) MARCOMA Auther 7600 CARROLL JO0000 MDFACED

DHMH 17 Rev 7/2009

State Registrar 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:25 2011 J<u>anuary</u> Medical <u>William W. Wade Sr.</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Catonsv</u>ille Charlestown Care Center If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 2 M 2 - F Months Days Hours (Month, Day, Year) 4/29/28 Maryland Director 216-20-4741 Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 715 Maiden Choice Lane 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates 27 is marked other than "natural", traumatic event, the Medical Exa Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police Police Officer 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be file alth and Mental H 27 is marked o ည Thomas Wade Mary Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Oneida, WI. 54155 1272 Pleasant Valley Dr. William W Wade Jr. / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 1/15/11 Baltimore, Maryland Olivet Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lice 3620 Wilkens Ave. Baltimore, maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ e disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ed by the a g | Unknown P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? [출 Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 읻 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Natural Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) up Maleken Vam 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1318AM IROTEN JANUARY HELEN 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARE S'Y KES VILLE CARROLL TRANSITIONS HEALTH 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🙀 F Maryland 92 June 9, 1918 Director 212-07-1020 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event; the Marical Evantinar must be mutified an any injury or other traumatic event; the Marical Evantinar must be mutified and pines. 1 ☐ Yes 2 ☑ No Director Manchester Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21102 4695 Egg Hill Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Sheets William Swoboda 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3436 Uniontown Road; Westminster, MD 21158 Gail Hosmer Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Lorraine Park Cemetery 1/6/2011 Woodlawn, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lice MD 21228 1630 Edmondson Avenue; Catonsville, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and burial-trar Due to (or as a consequence of): the attending physician hed for use as the burial Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) I □Yes 2 ₩No P.0. detached 9 DUnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 **▼**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 05

M.D. 1838 GREENE TREE ROAD # SUD PILLEVILLE MD LEONARD RICHARDSON 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

057722

29d. Date signed (Month, Day, Year)

4 2011

JANUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5perFH, G911, 1/11/2011, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Leroy Wheeler **January** 2011 9:01 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Baltimore** 4b. City, Town, or Location of Death **Examiner** 18827 Spooks Hill Road Parkton if Under 1 Year If Under 24 Hrs. Sex 1XXM 2☐F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours October 20, 1959 Baltimore, Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkton Maryland 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21120 United States 18827 Soooks Hill Road 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Divorced 4 Divorced Completed 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Clements Welding Elementary/Seconday (0-12) College (1-4 or 5+) Steel Erector and Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be filec tment of Health and Mental Hi tant: If item 27 is marked otl jury or other traumatic even unknown Lillian Barron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18827 Spooks Hill Road, Parkton, Maryland 21120 Sharon Wheeler - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wiseburg United Methodist Church Cenetery Department of 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Important; 4 ☐ Donation 5 ☐ Other (Specify) any injury Jan. 5,2011 White Hall, Maryland 21. Signature of Funeral Service License Evans Funeral Chapel and Cremation Services - Monkton 16924 York Road, Monkton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed Yes 2 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🛚 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) the funeral 27. Mann of Death 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After 5 Pending injury Natural 1 Tes 2 🔲 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurses Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 30. Name and addr pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Temperance Estelle Wenzel 1:31 January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hart Heritage Harford Street If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** onth, Day Y Months Days Hours Min. NOV. Year) 1926 Mary Land 1 🗆 M 2 🛣 F Yrs. Director 84 218-22-7216 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland all Hygiene.
ad Hygiene.
d drhey than "natural", or items 23a or 28a-f sho do dher than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 917 Candlelight Ct. 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be filed ent of Health and Mental H nt: If item 27 is marked ot y or other traumatic ever ဂ္ Marion Chapman Smith Lillian (nmn) Ammon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Shearman / Daughter 908 Charisma Ct., Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State metery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once, Hilltop Service Corp. 1-5-11 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ral Service Licensee 22 Name and Address of Facility Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OVOWANY Physician/ 6 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): and -tran that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🙀 Other (Specify) 2 🗆 No 1 Yes Assisted 유 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Living Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate

within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director,

State Registrar

Medical

SPANLS 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Investigation Could not be

MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Accident
3 Suicide
4 Homicide

29a. Certifier (Check

> MAC DHAI 611 Pegistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗌 Yes

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 🗌 No

Location (Street and Number or Rural Route Number, City or Town, State)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bonnie wright Month Physician/ 1:25 PM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice @ Northwest Hospital Baltimore Randallstown Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Feb 27, Months Days Hours 220-38-0366 Mary Land 68 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 ី No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral 8325 Bear Creek Drive 21222 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Paints Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Arthur C. Miller Rose E. Bishop permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 Is marke any injury or other traumatic to once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8325 Bear Creek Drive Dundalk, Maryland 21222 Ralph E. Wright, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc. 01/03/11 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Hod Kins Lymphoma Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskajpuneM.D DOUS7465 1/2/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 2120 5 2835 Smith N.S. Rajapakse, MID N. 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN U 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Ma	-	partment of H e <i>rtificate of L</i>				
			eg. No:	3 Time of Death					
	Physicia		1. Decedent's Name (First, Middle, Last) Alma L. Witte				2. Date of Deat January	Day Year	
armin.	Medic Examin		4a. Facility Name (if not institution, give street and number)	Location of Death	ouridar j	4c. County of Dea			
	Xaitiiii	CI	Gilchrist Hospice	owson		Baltir			
	Funeral			e (In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Birth	g. B	irthplace (State or Foreign
	Director		217-24-5954	82 Yrs.	IVIORITIS Days	Hours Will.	Dec 26	1928	Maryland
	ld sow	_	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location	-			10d. Inside City Limits
	arylar a-fsl fied	Director	Maryland Baltimore		nerville				1 ☐ Yes 2X No
	he Ma or 28 noti	Dir	10e. Street and Number		10f. Zip Code		1	log. Citizen of What C	ountry?
	with t	eral	1804 Broadway Road		2109	3		United S	States
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S.	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Am	erican Indian,
စ္တ	fter d , or i	by	1 ☐ Never Married 2 ☐ Married	No	1 ☐ Yes 2X No		nican, etc.)	Black, Whi	
21215-0036	urs a tural'	Completed	3 ★ Widowed 4 □ Divorced Year or Dates.					Specify: Wh	nite
5	72 ho "na" r ledici	uple	15. Decedent's Education (Specify only highest grade completed)	I (Giv	cedent's Usual Occup re kind of work done o DO NOT use retired)		ing	16b. Kind of Business	s Industry
7	ithin ene. r thar	Con	Elementary/Seconday (0-12) College (1-4 or 5	·+)	ninist <u>rati</u>	vo Acciet	ant	AT & T	
p	led w Hygi othe	Be	17. Father's Name (First, Middle, Last)	ACI	dinisciaei	18. Mother's Nam			
lan	l be fi fenta rked ric ev	10	Corinto Mattucci			Elsa	Crue		
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street a	and Number or Rura	al Route Number,	City or Town, State, Z	ip Code)
	and 2 s Health tem 27		Frederick W. Witte/son		Guinevere (Court Ba	ltimore,	Maryland	21237
ore	t of H If ite or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State		position (Name of rematory or other plac	e)	Date	20c. Location - City o	r Town, State
Ę	t. Pag tmeni tant: ijury		4 Donation 5 Other (Specify)		mey Crema			Woodbine,	
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licenses Auanita R Homos	M00957 E	22. Name and Addres Soing Home Beverly L.	crematio Heckrott	n Servic e, P.A.	e P.O. Box Clarksvill	k 784 Le, MD 21029
			23a. Partyl. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line		nter the mode of dyin	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	hysician/	6 9	Immediate Cause (Final disease or condition	moni	9				Onset and Death
	Medical Examiner		resulting in death) Duje to (or as a	consequence of):	1.3 ALA L.	- 1 . 1		da- 1	144.00
		er	if any, leading to immediate Due to (or as a	consequence of):	suctiv	(Vim	moury	CIPLLE	years
	ed nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Consequence on.		•	/		
	xecut n and al-tra	Exa	that initiated events resulting in death) Last C. Due to (or as a	a consequence of):					
0	cate be executed physician and s the burial-transit	edical	d						
876	ifficate ng phy as th	Med	IF FEMALE:		-				
۳ ×	endir r use	an/I	23b. Was decedent pregnant 23c. If yes, outcome of		□ Ectopic pregnanc	y		23d. Date of de	
Bo	deatl he att led fo	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	time of death 5	Other (specify)	-		Month	Day Year
o	at the d by t letach		Part II. Other significant conditions contributing to death but	ut not resulting in the	e underlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ν, σ	requires that the der been signed by the s should be detached	d by			, ,		1 X Ye		Probably 4 🗆 Unknown
ğ	requi	ete					24a. Was ar		utopsy findings available
ecc	sician: The law r s certificate has b lirector, page 2 s	Completed				-	autops perform	y prior to ned? death?	completion of cause of
<u>=</u>	in: Th		25. Was case referred to medical		26. Pla	ace of Death (Check	1 Yes 2	No 1 ☐ Ye	s 2 No
Ĭţŝ	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatie	ent 2 🗆 ER/Outpat	_ Othe			nce 6 Other (Spe	CITY MOSPIGE
o	g Ph	te:	27. Manner of Death 28a. Date of injur	y 28b. Time	of 28c. Injury	at at	28d. Describe ho		
0	endin sath. or; Afi he fui	fica	2 Accident Investigation			Yes 2 No			
Division of Vital Records, P.O. Box 68760	I or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, s . <i>(Specify)</i>	street, factory, office		28f. Location (Str City or Town,	eet and Number or Ru State)	ural Route Number,
Ω	pital o		Ode Codifies A Codificial District To the	my knowledge don't	h occurred at the time	data and plans	d duo to the	o(a) and manner as -+	ated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certiffer (Check only one) 2 Certifying Physician: To the best of r 2 Medical Examiner: On the basis of ex 3 Certifying Nurse Practioner: To the basis of ex	camination and/or inve	estigation, in my opinio	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
٠.	To the within To the compl	_	29h Signature and title of certifier		29c. License	number	25	nd Date signed (Mont	th. Day. Yearl
			30. Name and address of person who completed cause of de		D	58303	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	anvery	3 Zeil
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type	Print		· · · · ·	1	
			AANUN] CHAMES MD	6701 1	v Cherk	7 21	1 moso	V MO	
	Stat Registra	е	31. Date filed (Month, Day, Year) 32. Registral	r's Signature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Daniel 6:00PM Young Januari 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death County of Death Creci YA Maryand AY If Under 1 Year 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ₺ M 2 🗆 F Months Davs Hours Director 229-32-9628 79 Virgi<u>nia</u> Usual Residence of Decedent Strysician: YounG, Charles On Maryland 21215-0036 23a or 28a-f shov 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No VA Rockingham Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7013 Ottobine Road 22821 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 X Divorced If Yes, Give Year or Dates. War Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with nand Mental Hygien is marked other th 12 Equipment Service Employee Northwest Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel B. Young Blanche Lee Covington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is James Derek Young - Son 7013 Ottobine Road, Dayton, Virginia 2000 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place injury or 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Comfort Cemetery | Jan. 7,2011 | Alexandria, VA Mt. Signature of Funeral Service License 22. Name and Address of Facility Stover Funeral Home, Inc. 177 North Holliday St., Strasburg, VA 22657 Name 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Mermoura **TURUORU** Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached f signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of has autonsy performed? ☐ Yes 2 X N certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify, within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practice the best of my liminately as death continued at the time, date and place, and day to the daugue (e) and mainly as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 2a) (Type, Print) Health Care System Perry Point Mails

State Registrar Soolvack AY

 $\mathcal{M}_{i}\mathcal{D}_{i,j}$

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Magdalene 2. Date of Death 3. Time of Death В. Zamary Year Month 1/3/2011 Day Physician/ 3:25pm M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 1220 Maxwell Lane Huntingtown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 XF 1719719<u>1</u> 91 291-18-3516 Slovania Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Huntingtown Calvert 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 Funeral 1220 Maxwell Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Was Deced Armed Forces? 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: If Yes, Give 3℃Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Magdalene Staresinic 17. Father's Name (First, Middle, Last) မ Rock F. Brinsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1220 Maxwell Lane, Huntingtown MD 20639 Stephen Zamary Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calvary Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/8/2011 Youngstown, 4 Donation 5 Other (Specify) re of Funeral Service Licensee Victor P. 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD الديا(23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adenocara noma of untrova Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 [Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Vear 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 Yes 2 No After this certificate To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one. director, Be examiner?
1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 유 28a. Date of injury (Month, Day, Year) nin 24 hours after death.

the Funeral Director: After thi

npleted filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number eand ti to completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Registrar's Signature

Mprimac

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra 2. Date of Death Decedent's Name (First, Middle, Last) Month Year Physician/ 8:58P MARY REGINA AIREY IAN 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY KESWICK HOME BALTIMORE 8. Date of Birth (Month, Day, May 6. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7, Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 🗆 M 2 🕮 F Director 80 Mary land 212-26-1078 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Baltimore City 1x Yes 2 No Baltimore City Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21206 6520 Belle Vista Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the Telephone Co. Telephone Operator 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George Hallikas Mildred E. Theise should be and is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 shment of Health a 2702A Wildberger Ave. Baltimore, Md. George C. Airey (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 1-10-2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Vicensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANCED DEMENTIA unknown disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month. Day Year Pregnant at time of death g 🗌 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed I funeral director, page 2 should be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2 □/No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No death. Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059056 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Salvic

10

31. Date filed (Month, Day, Year)

MO

82. Registrar's Signature

700 West yoth St

Balt

MO

21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Henry Andrew Abremski Medical 01 10:00 PM 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 1008 Whitaker Mill Road Harford Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🛛 M 2 🗆 F Months Days Hours Min **Director** 08/17/1930 212-26-6226 Yrs 80 Maryland Usual Residence of Decedent show 10a. State 10b. County with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the M-dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Harford Joppa 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1008 Whitaker Mill Road 21085 S.A. Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 XMarried 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 <u> Machinest - Metal-Lurgist</u> Bethlehem Steel Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry J. Abremski Teresa Eichhorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) 1008 Whitaker Mill Road - Joppa, Maryland <u>Mardell M. Abremski</u> other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department or Important: If any injury or once. ō 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory, Inc. 01/10/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. (aa 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ dehydration 2 weeks disease or condition Medical resulting in death) Due to (or a a consequence of): **Examiner** End stex demenha Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Vear 2 No been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASCUD 1 Yes 2 XNo 3 Probably 4 Unknown Seizures 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has performed? Yes 2 No 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case re erred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

10

DHMH 17 Rev 7/2009

Registrar

30. Name and address

JAN

Klousz

0

Kenwood

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D31295

13a 1 Amose

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician December Name (First, Modile, Last) 2 Date of Death Sarray Name (First, Modile, Last) 1 Prant Amend 1 Prant 1 Pr			1- For State Registrar	o or maryiana	Cei	rtificate of		and wich	itai i i		Reg. No.	Garage 1 1	00121
46. Seathly thereof inclination, please enteres are namedy 18. Only Town of Location (Please Bell Air 18. Only Town of Location (Please) Bell Air (Please) Bell Air 18. Only Town of Location (Please) Bell Air			1. Decedent's Name (First, Middle,L	ast)						2. Date of De	ath	Voor	
Rear common area of 1300 Sheridan Place Page P	ledical Exam	iner	narry Frank							January :			
Social Social Social Public Control Co				,		4	•	vn, or Location	of Death		- 1		th
27-7-2-8709						and briefly do		Versiliens	0411	In n			
The state of December 1 to 100 potential results of the state of the s			045 50 0500	, i	e (in yrs. i	•						Fore	ign
Total				X M 2 F		46 Yrs.				May 06	, 196	4 c	ountry) Maryland
Second Color	, un				10c. City,	Town or Locati	on						10d Inside City Limits
Security	*	١.											
Security	rylan a-fsi	턍					10f Zin Co	nde			10a Citi	zen of What Cou	
1. Was December of Hispanic Chipy 1 Specify 198 or No. 1.4 Race. American Indian, Black, Writin acc. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chipy 1 Specify 198 or No. 1.5 Was December of Hispanic Chip 198 of Hispanic Chip 19	re Ma or 28	Sire		it G						-			and y :
23. Significant conditions 24. Significant conditions 25. Significant conditions 26. Significant conditions 27. Significant conditions 27	with the 1.8 23a e not				Ever in U.	.S. 13. Was		·	igin? (Sp	ecify Yes or N			rican Indian Black
23. Significant conditions 24. Significant conditions 25. Significant conditions 26. Significant conditions 27. Significant conditions 27	leath r item	l e	1 X Never Married 2 Marri		Z No								, , , , , , , , , , , , , , , , , , , ,
23. Significant conditions 24. Significant conditions 25. Significant conditions 26. Significant conditions 27. Significant conditions 27	after o		3 Widowed 4 Divorc	ed If Yes, Give Year	1 110	1	Yes 2X	No specify.	:			Specify: Wh	ite
23. Significant conditions 24. Significant conditions 25. Significant conditions 26. Significant conditions 27. Significant conditions 27	lours latur		15. Decedent's Education (Specify		pleted)								
23. First farm the disease or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm, leading in immediate interesting in death) last or conditions; farm, leading in immediate conditions. 24. The district of the district of the district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. The district or district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. What december pregnant in the past 2 months? 26. Due to (or as a consequence of): 27. What december pregnant in the past 2 months? 28. First farm the disease or injury that initiation death) last or conditions. 28. First farm the disease or injury that initiation death or past 2 months? 29. Unknown 29. What are of beath or past 2 months are death 3 months are	16 n 72 h		Elementary/Secondary (0-12)	College (1-4 or 5	+)			g ille. DO NO	use retir	eu)			or Graphics
23. First farm the disease or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm, leading in immediate interesting in death) last or conditions; farm, leading in immediate conditions. 24. The district of the district of the district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. The district or district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. What december pregnant in the past 2 months? 26. Due to (or as a consequence of): 27. What december pregnant in the past 2 months? 28. First farm the disease or injury that initiation death) last or conditions. 28. First farm the disease or injury that initiation death or past 2 months? 29. Unknown 29. What are of beath or past 2 months are death 3 months are	003 withi giene.	E	17 Fethada News /First Middle La	-41	_	TIMICE		Lessi					
23. First farm the disease or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm, leading in immediate interesting in death) last or conditions; farm, leading in immediate conditions. 24. The district of the district of the district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. The district or district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. What december pregnant in the past 2 months? 26. Due to (or as a consequence of): 27. What december pregnant in the past 2 months? 28. First farm the disease or injury that initiation death) last or conditions. 28. First farm the disease or injury that initiation death or past 2 months? 29. Unknown 29. What are of beath or past 2 months are death 3 months are	filed off			st)								Surname)	
23. First farm the disease or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm, leading in immediate interesting in death) last or conditions; farm, leading in immediate conditions. 24. The district of the district of the district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. The district or district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. What december pregnant in the past 2 months? 26. Due to (or as a consequence of): 27. What december pregnant in the past 2 months? 28. First farm the disease or injury that initiation death) last or conditions. 28. First farm the disease or injury that initiation death or past 2 months? 29. Unknown 29. What are of beath or past 2 months are death 3 months are	212 uld be Ments mark			(Type, Print)	_	19b. Mailing	Address (Street and Nur	nber or R	LLLIAN B	urke mber Ci	ty or Town State	e Zin Code)
23. First farm the disease or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm, leading in immediate interesting in death) last or conditions; farm, leading in immediate conditions. 24. The district of the district of the district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. The district or district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. What december pregnant in the past 2 months? 26. Due to (or as a consequence of): 27. What december pregnant in the past 2 months? 28. First farm the disease or injury that initiation death) last or conditions. 28. First farm the disease or injury that initiation death or past 2 months? 29. Unknown 29. What are of beath or past 2 months are death 3 months are	AD 2 sho h and 27 is					7.5							o, 2.p 3 333)
23. First farm the disease or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm, leading in immediate interesting in death) last or conditions; farm, leading in immediate conditions. 24. The district of the district of the district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. The district or district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. What december pregnant in the past 2 months? 26. Due to (or as a consequence of): 27. What december pregnant in the past 2 months? 28. First farm the disease or injury that initiation death) last or conditions. 28. First farm the disease or injury that initiation death or past 2 months? 29. Unknown 29. What are of beath or past 2 months are death 3 months are	e, e, land I and Healt item		20a. Method of Disposition		20b. F	Place of Disposit	tion (Name	of cemetery		Date			Town, State
23. First farm the disease or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areal, shock or heart allury/flust only one cause or each line. 23. First farm, leading in immediate interesting in death) last or conditions; farm, leading in immediate conditions. 24. The district of the district of the district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. The district or district or death or respiratory areal, shock or heart allury/flust only one cause or each line. 25. What december pregnant in the past 2 months? 26. Due to (or as a consequence of): 27. What december pregnant in the past 2 months? 28. First farm the disease or injury that initiation death) last or conditions. 28. First farm the disease or injury that initiation death or past 2 months? 29. Unknown 29. What are of beath or past 2 months are death 3 months are	nor Pages ent of nt: If		1 Burial 2 A Cremation 3	Removal from Sta	te Eva Cre	ns Tunera	I Char	el & Air	Janua	ary 7,	For	est Hill.	Maryland
Physician Medical Examiner Continue Con	altir mit. I partm porta ury o	1 13	21. Signeture of Funeral Service Lice	ensee Jeffre v R	Tes	term 22 Na	ame and Ad	dress of Facility	y 7 0 4	711	1-0-		- ·
Part No. Other significant conditions Part No. Other significant Part No. Other signific	ii II De ထ	V: 33	Lethen K Tes	Luman	(MO15	43) 3 N	s rune ≫port	rai Chap Drive, R	er & (brest	remetia Hill, M	n Ser aryla	vices Bel nd 21050	. Air
TRAINING TO 289 ON OR O'CL State (Final disease or condition resulting in death) The part of the part of the cause of the cause of the cause of death? The part of the cause of the cause of the cause of death or conditions. The part of the cause of the cause of death or conditions. The part of the cause of the cause of death or conditions. The part of the cause of death or cause of death or conditions. The part of the cause of death or conditions. The part of the cause of death or cause			23a. Part I. Enter the disease, or con	nplications that caused t	he death.	Do not enter the	e mode of d	ying, such as c	ardiac or	respiratory an	rest, sho	ck, or heart	Approximate Interval
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (cause. Enter Underlying Cause) (crosses or injury that interest and cause. Enter Underlying Cause (cause. Enter Underlying Cause) (crosses or injury that interest are events rescuting in death). Last Use to (or as a consequence of): Due to (or as a consequence of):													
The composition of the compositi					quence of	f):							
Column C		er	Sequentially list conditions,		quence of	f):							
Column C		m	(Disease or injury that initiated	2									
Continue	ited d ansit		· · · · · · · · · · · · · · · · · · ·	-	quence of	'):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	execular an an an an an	ical											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	60, ate be shysic te buri	Med	IF FEMALE:	23c. If yes, outcom	e of pregr	nancy		_			23d	Date of deliver	<u> </u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	687 ertific ding p			1 Live birth		2 Feta	al death	3 Ectopic	c pregnan	су			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	OX eath c	Sici	1 Yes 2 No 9 Unknow	_1 =	me of dea	ath 5 Othe	er (Specify)				1		59
The state of the s		F	Part il. Other significant conditions		but not re	sulting in the un	iderlying cai	ise given in Pa	ert I	23e. Did to	obacco i	use contribute to	the cause of death?
The plant of the p	S 20 9					3	, ,						
26. Place of Death (Check only one) 28. Was case referred to medical examiner? 1	ds, equir	e e					-			24a. Was	an	24b. Were au	itopsy findings available
26. Place of Death (Check only one) 28. Was case referred to medical examiner? 1	COF law r has b	휌											completion of cause of
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sispature and title of certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Re : The ificate r, pag		25 Mas assault day day	· · · · · · · · · · · · · · · · · · ·		_	00.5				2 No	1 🗸 Ye	es 2 No
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sispature and title of certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	is cert		examiner?	 Hospital: 1 Innation	t 2	FR/Outpatient		IOther -			Dooidos	C - O O O O O O O O O O O O O O O O	. C
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sispature and title of certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	g Phy g Phy her thi	읩	1 Yes 2 No	28a Date of Injur	, 	<u> </u>							- Scene
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sispature and title of certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	ath.	틸	Pending	1 0 0040			1[Yes 2	ls.			,	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sispature and title of certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	/iSi	밀		28e Place of Init			factory, off	ce building, etc	c. 2	28f. Location (Street an	nd Number or Ru	ral Route Number, City
29b. Signature and title of certifier 29b. Signature and due to the cause (s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	illed i	Ę	determin		i				1:	or Town, S 300 Sherida	state) n Place	, Bel Air, MD	
O.C.M.E. January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	24 ho 24 ho Funce		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated										
O.C.M.E. January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Fo the within Fo the	影	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		Ž	6)/40)/4,0)///2011								nth, Day, Year)		
Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			Ocefor Val	10 5/ de	*	1500		.C.M.E.			Janu	ary 3, 2011	
	Nu	j			•	•	Dalties -	o Stroot D	altina -	MD 0400	2		
Registrar JAN 0 7 2011 Server B. Garles	1/4						Baitimor	e Street, Ba	aitimore	e, MD 2122	دے		
		trar	JAN 0 7 2011	JP3	J. 14	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:00 AM 2011 Mary Gertrude Archabault January /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care - Roland Park Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days 1 ☐ M 2 🖸 F Yrs. May 23, 1915 95 Maryland 214-14-8822 Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21211 3002 Cresmont Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify. þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 11nk 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Efementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goerge Washington McCleary Mary Elizabeth Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3002 Cresmont Avenue; Baltimore, Maryland 21211 Jeff Archaubault - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ⊠ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board ature of Funeral Service Licens Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical 26. Place of Beath (Check on one examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yəs No No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manny of Death 28a. Date of Injury (Month, Day Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 be detached for Division of Vital Records, icate has been significate page 2 should b certificate has funeral director. death. within 24 hours after death
To the Funeral Director:
completely tilled in by the Hospital To the !

Funeral

Director

Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner risust be natilised at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s eny injury or other traumatic event, the Madical Examiner runal once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

the Maryland

With

State Registrar

Medical

(Check only one)

29b. Signature and tige of certifier

31. Date filed (Month

0

8813 Waltham Wood 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0069314

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 2011

29d. Date signed (Month, Day, Year)

Rd Parpolle MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 6, 2011 Pear 6:30 A M Michael Armetta Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Baltimore 3516 Hiss Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, 1 X M 2 □ F Months Hours Min 216-20-2534 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10d. Inside City Limits Director 1 Tes 2 X No Baltimore Marvland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3516 Hiss Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give 1943 – 1943 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hyglene. Truck & Farm Elementary/Seconday (0-12) College (1-4 or 5+) Expeditor Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 Constantino Joseph Armetta, Sr. Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Maryland Wife 3516 Hiss Avenue Baltimore, Gloria M. Armetta Baltimore, 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Dulancy Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 1-10-2011 Timonium Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, ž 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner CONCESTIVE Sequentially list conditions, cause (Disease or linjury Due to (or as a consequence of). and -transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the t attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILLER 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? D. ABETES 24a Was an autopsy autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred

Box 68760 P.O. Records, Hospital or Attending Physician: Division of Vital s after death.

1 Natural

2 ☐ Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

30. Name a

(Check

only one) 29b. Signature 5 Pending

Investigation 6 Could not be

determined

completed

Registrar DHMH 17 Rev 7/2009 injury

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

DIERRE DR

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

dress of person who completed cause of death (Item 23a) (Type, Print)

O SISTUR

32. Registrar's Signature

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

44560

STIDE

28f. Location (Street and Number or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Roscoe Yea Physician/ 6:30P M Bryant January 2011 Medical 4a. Facility Name (if not institution, give street and number, County of Death Examiner anda 8 If Under 8. Date of Birth Birthplace (State or Foreign Country) st birthday **Funeral** Hours 1 M 2 F Yrs **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. City, Town or Location notified at Director 1 Yes 2 No HMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 3820 Road 21244 1/24/5 Coronado other traumatic event, the Medical Examiner must be Funeral items 23a permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "many injury or other than "many Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Newer Married 2 Married þ Yes 1 Yes 2 No Specify If Yes, Give 3 ☑ Widowed 4 ☐ Divorced lac Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) ain tenan Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ည Informant's Name/Relations p (Type. P. To State, Zip Code) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Na cert etery, crematory or 20a. Method of Disposition 20c. Location - City or Town, State or other p 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Name and Address of Facility ineral Services once, Signature of Funeral Service Licensee mD21133 23a. Part 1. Enter he disease, or complications that caused shock, or heart failure. List only one cause on each line. he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Dementia Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Find Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the all ending physician and completed filled in by the funeral director, page 2 should be detached fcr use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be ivision of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 🗹 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 6 Vother Specificat hospice 2 🗹 No 4 Nursing Home 5 Residence 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending 1 Natural 1 🗌 Yes 2 🗀 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination shows infragrams, and place, and due to the cause(s) and manner as stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 29b. Signature and title of certifier

Ray upawa M. D 29c. License number 29d. Date signed (Month. Day, Year) 00057465 1/7/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203, Baltimore, MD. 21209 N. S. Rajapalse, M.D. 2835 Smith AV. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 0 20 Jarke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6, 201 Year Jahuary Ethel Segerman Braun 8:55A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Glen Arm 12815 Dulaney Valley Road 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 05/05/1912^(ear) Maryland 98 Director 216-28-6969 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 ☐ Yes 2XX No Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 12815 Dulaney Valley Road 21057 USA items. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🗖 No þ 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", 3 Widowed 4 X Divorced Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ည George Carter Segerman Edna Marie Geise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Son P 0 Box 4007 Greenville Delaware 19807 Wilson J. C. Braun Jr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot 1 💢 Burial 2 🗌 Cremation 3 🗀 Removal from State 01/14/2011 New Cathedral Cemetery Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funer IS 22 Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME INC 6500 York Road Baltimore, Maryalnd 21212 23a. Part 1. Enter the disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Onset and Death Immediate Cause (Final Physician/ CONGESTUE HEARLT disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner YSM4090 ARTER Sequentially liet conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): « Examine YPERTENS LOW attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Ectopic pregnancy Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes been significant Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Mann Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Naturai 5 Pending work' 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur? and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 2011 address of person who completed cause of death (Item 23a) (Type, Print) 30. Nam TOWSON SIZ OSCER ORIVE 32. Registrar's Signature State 1 0 2011 Registrar Darke.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For		State of Ma	arylanc	-	artment of H		Mental Hy	giene	a also		
		State Registrar	(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4)	_	Cer	tificate of D	eath	2. Date of De	Reg. No.	111		32
Physicia	n/	1. Decedent's Name	e (First, Middle, Las Berniker	i)					Month 1	Day 8	Year 201		N.4
Medic Examin	_	4a. Facility Name (if		street and number)			4b. City, Town, or	Location of Death	1 4		ounty of De		4
LAGITITI	C.	Gilch	ist Hosp	ice Care			Tows	son			Balti	more	
Funeral Director		5. Social Security N	-8420 6. Se	7. Age	e (In yrs. las 88	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 1922	9. E	irthplace (State or For	reign
bu wor	_	Usual Residence of 10a, State	Decedent 10b. County		10c. City,	Town or Lo	cation		_	_		10d. Inside City Lir	imits
larylar 3a-fsl iffied	Funeral Director	MD	Howard		E	Ellico	tt City					1 ☐ Yes 2 🛂	X No
the M or 28	اقا	10e. Street and Nun					10f. Zip Code			10g. Citize	n of What (Country?	
s 23a nust k	nera 	3989 Hi	gh Point	Rd.			21042				nited	States	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status1 Never Marr3 Widowed	ied 2 XMarried 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 If Yes, Give Year or Dates.		- 1	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☒No		ecify Yes or No- Rican, etc.)	i	. Race - An Black, Wh pecify: W.		
5-0 2 hour	plet	(Spe	15. Decedent's E			(Give	dent's Usual Occupa	ation uring most of work	king	16b. Kind	of Busines	s Industry	
121 thin 73 sne. than	Completed	Elementary/Sec		College (1-4 or 5	i+)	Ìife. D	O NOT use retired) Attorney	,			Lega	1	
nd 212 iled within I Hygiene. other tha vent, the M	a	17. Father's Name (First, Middle, Last)	<u> </u>	ļ			18. Mother's Nan	ne (First, Middle,	Maiden Su			
arylan	욘	Unknow						Unknow	n				
Marylanc 2 should be file 1th and Mental I 27 is marked or r traumatic ever		19a. Informant's Na	me/Relationship (T)	/pe, Print)			ng Address (Street a	and Number or Rui	al Route Numbe				
y, M		Jeanne	Berniker	- Wife		<u> </u>	High Poi	nt Rd.	Ellicot	t City	y, MD	21042	
Baltimore, Maryla permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disp 1		Removal from State	ce	metery, crei dowri	osition (Name of matory or other placed or oth	Pk. 1/	Date 12/11	E.	lkrido	or Town, State	
Balti permit. Departr Importa any inju		21. Signature of F	ral Service Li) ins	see	2507.4	22	2. Name and Addres	s of Facility Ha	rry H.	Witzke	e's Fa	mily F.H.	Inc
m go = # 9		-	arx True		M014						ott C	ity, MD 21	.043
Pnysician Medical Examiner	es An	23a. Part 1. Enter 1 shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only o Final	plications that caused ne cause on each line a. Due to (or as	alt	atic	er the mode of dyllig		Paul La			Approximate Interval Betweer Onset and Deatl	
e e.	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	nmediate rlying iinjury s	b. Due to (or as c. Due to (or as									
Box 687 death certifica he attending p	9	IF FEMALE: 23b, Was decedent in the past 12 1 Yes 2 9	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		23	d. Date of o	delivery Day Year	ŕ
P.O. that the ned by t	by Pl	Part II. Other signit	ficant conditions c	ontributing to death b	out not resu	Iting in the	underlying cause giv	ren in Part I.	23e. Did	tobacco use	contribute	to the cause of death	n?
uires n sigr									1 🗆	Yes 2 🖸	√ lo 3 □	Probably 4 Unk	nown
Record The law requate has bee	Completed				_				24a, Was auto perf 1 \(\sum \) Yes		prior t death	autopsy findings avail o completion of cause ? 'es 2 No	lable e of
cian:	Be (25. Was case referr examiner?		Hospital:				ace of Death (Che	ck only one)				
Division of Vital Records, ral or Attending Physician: The law requires s after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be	은	1 Yes 2 27. Manner of Deat 1 Natural 2 Accident		28a. Date of inju (Month, Da	iry :	ER/Outpatie 28b. Time o injury	work	4 □ Nursing H	ome 5 Res 28d. Describe			ecify) Hasspi	. ت
Division all or Atter as after dea Il Director de In by the	Certificate:	3 Suicide 4 Homicide	6 Could not be determined				reet, factory, office		28f. Location (City or To		Numb e r or I	Rural Route Number,	
ne Hospit n 24 hourn ne Funera pleted fille	Medical	(Check 2	☐ Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or inves	stigation, in my opinio	on, death occurred	at the time, date	and place, a	nd due to th	e cause(s) and manner	r stated.
To the with To the com	_	29b. Signature and	tide of certifie		. 7		29c. License					nth, Day, Year)	
		1/1/	hab		MD		D7	1040		01	08	2011	
2				completed cause of c				1 :					
		ARATHE 31. Date filed (Mont	th, Day, Year)	6701 N	CHA:	PLES	ST , SUI	112 10	5 BA	LTIM	KE	MD 2150	24
Sta Registra		JA		32. Registr	1.	your	()						
DHMH 17 Rev 7/20	009		100 TO 100 W	4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:45 PM LISA JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A BALTIMORE BON SECOUR HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours (Month, Day, JAN 2 **Director** MARYLAND 47 217**-**88-8543 Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MARYLAND HARFORD CO ABERDEEN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 W. BEL AIR AVENUE 21001 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. ò 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 ? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Market once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSES ASSISTANT 10th grade HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MILDRED COPELAND EDWARD BRANCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Williams/Mother 700 Bel #126, Aberdeen, Md., <u>Air Ave.</u> 21001 20a. Method of Disposition
1 ☐ Burial A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) METRO CREMATORY 01-07-11 BALTIMORE, MARYLAND 21. Signature of Euseral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD,
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ムナチム圧 CARDIOMYOPATM END disease or condition Medical resulting in death) Examiner VER DISEAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine -transit みとひから RENA2 Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 40 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: <u>ام</u> 1 🗌 Yes 2 💢 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work' 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D23300 ND

Registrar

State

20002

Registrar's Signature

130N SEKOURS

13かと下いらず,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAREZ

SUDKIR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departmen State of Maryland / Departmen Registrar Certificate	it of Health and I e <i>of Death</i>	Mental Hygie Reg.	0011	00131	
	Physicia	ın/	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death 8:48 P M	
	Medic Examir	cal	Mary L. Buddenbohn 4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death		1 4c. County of Death		
1	2		Stella Maris Hospice T	imonium		ore		
	Funeral Director		5. Social Security Number 213-26-7294 6. Sex 1	1 Year If Under 24 Hrs. Days Hours Min.	3. Date of Birth	931 Mar	thplace (State or Foreign Y Land	
	yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Parkvi	116			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	the Mar or 28a- e notifi	Director	10e. Street and Number 10f. Zip	Code	10g.	Citizen of What Co		
	th with ms 23a must b	Funeral		21234		USA		
8:48 p.m.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Forces? If Yes, spec	dent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto 2 X No Specify:	o Rican, etc.)	14. Race - Ame Black, White Specify: whi	e, etc.	
:48 -48	72 hou an "nat Medica	Completed	life. DO NOT use	rk done during most of worl e retired)	king	o. Kind of Business	Industry	
C	d withir tygiene ther tha nt, the	Be Co	9 Homenake			Home		
6, 2011 Maryland	should be file and Mental H is marked of raumatic ever	To B	17. Father's Name (First, Middle, Last) Lawrence M. Connelly		ne (First, Middle, Maid et Webster	en Surname)		
	d 2 shoul alth and I 27 is m er trauma		19a. Informant's Name/Relationship (Type, Print) Norbert Buddenbohn, Sr-spouse 19b. Mailing Address 8810 Walt	Street and Number or Ruither Blvd. Ap	ral Route Number, City ot .1217–Pai	or Town, State, Zinckville, M	aryland 1234	
JANUARY	Page 1 an nent of He int: If iten iry or oth	17. I	20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nan Evanse Friedrand Crematic	ne of Milabel On-belair Jar	Date 200 1.11,2011 F	. Location - City or orest Hil	Town, State	
JAN	permit. I Departn Importa any inju			d Address of Facility Funeral Chap Harford Road		emation S Marylan	ervices d 21234	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.				Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) LEUKEMIA Due to (or as a consequence of):				Onset and Death	
7	Examiner	je je	Sequentially list conditions, b.					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events c.					
	re te be executed physician and the burial-transit	sal Ex	resulting in death) Last Due to (or as a consequence of):					
NHIN 8760	tifice te l ng phys as the	Medical	IF FEMALE:					
BUDDENBOHN P.O. Rox 6876		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic prognant at time of death 5 Other (sp. 9 Unknown)			23d. Date of de Month	ivery Day Year	
	uires that the signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I.			the cause of death?	
MARY Division of Vital Records	The law requires ate has been sig bage 2 should b	Completed			24a. Was an autopsy performed 1 🗆 Yes 2 🔏	prior to	topsy findings available completion of cause of	
	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Chec	ck only one)		HOCDICE	
of C	ng Phys fter this ineral di	ate: To	1 Impatient 2 D Ervourpatient 3 D De	8c. Injury at work?	ome 5 Residence 28d. Describe how in		ify) HOSPICE	
icion	• Attendi er death. • ector: A by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined Suicide the Homicide Investigation 1 Suicide	1 Yes 2 No	28f. Location (Street City or Town, St		ral Route Number,	
.2	Spital or nours aft neral Dir I filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at	the time, date and place, a	and due to the cause(s) and manner as sta	ated.	
	the Ho hin 24 h the Fur	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in a only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occur	rred at the time, date and pla	ace, and due to the cau	se(s) and manner as	stated.	
	To with		29b. Signature and title of certifier 29c	License number	29d.	Date signed (Month	n, ∪ay, Year)	
	Ce V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7				
	Sta		JACKIE JONES, CRNP 2300 DULANEY VALLEY 31. Date filed (Month, Day Year) 32. R gistrar's Signature	KD. TIMONII	UM, MD 210	93		
	Reaistr	ar	U (CUIII / Marie M. M. Barks	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Pay 4, Physician/ Betty Robinson Bell 2011 4:15PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4516 Harford Rd. Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Age (In yrs. last birthday) (Month, Day, Year) 09/04/1933 1 M 2 K Min. Director 219-28-3072 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Baltimore 1- Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4516 Harford Rd. 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 ➡ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2. No Specify "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerk 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Raymond Robinson Mildred Elizabeth Vogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Ritger/Friend 6216 Ridgeview Ave. Balto, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o 1 Burial 2 **Cremation 3 **D Removal from State 7, Jan. 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crem 2011 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A. 8717 Green Pastures Dr. Balto, MD 21286 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) ise are speaks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and to (or as a consequence of physician Physician/Medical Division of Vital Records, P.O. Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Month Day Year Pregnant at time of death 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 2 No 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 HOOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 □ only one and title of certifier 29d. Date signed (Month. Dav. Year) 7/1 0 address of person who completed cause of death (Item 23a) (Type, Print) 09 31. Date filed (Month, Day, 21 20 State JAN 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Brian Arthur Bell January 3° 201 j 5:42 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Jan • 14, 1937 9. Birthplace (State or Foreign Country) Michigan Funeral . Social Security Number 7. Age (In vrs. last birthday) 1**X** M 2 □ F Days Director 382-34-9655 73 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director MD Montgomery Burtonsville 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a (Funeral 20866 United States 3504 Spencerville Rd. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after compartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other trainment. 1 Never Married 2 Married þ 1X Yes 2 No If Yes, Give 57-60 Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Local #602 Steamfitter Be 17. Father's Name *(First, Middle, Last)* Clifford Arthur Bell 18. Mother's Name (First, Middle, Majden Surname, Bernice Electa Williams ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Bell (wife) 3504 Spencerville Rd. Burtonsville, MD 20866 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State Jan. Date 5. 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory 2011 Beltsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service of Fun ral Service Licens M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure Medical resulting in death) Due to (or as a consequence of): Examiner Pulmonary Fibrosis Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Chronic Obstructive Lung Disease burial-transi Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Records. Lung Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2. No 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 🔀 No Other: 1 Yes 1 XInpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 💹 Natural 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident completed filled in by the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 3, 2011 D20562

DHMH 17 Rev 7/2009

State Registrar

10.51

Registrar's Signature

10215 Fernwood Rd. Bethesda, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry J. Levin, M.D.

31. Date filed (Month, Day, Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 1 Day 2011 7:40 P M JACK NELSON CHALK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 618 Lake Ave. Edgewood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Allo 1, Year 937 1**X** M 2 □ F Mary land 73 Director 216-34-9213 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎽 No Edgewood Maryland Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 618 Lake Ave. 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married X Yes a Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Foreman Lumber Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine Iona Shauck Howard Franklin Chalk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Lake Ave., Edgewood, Maryland 21040 Elizabeth Chalk / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State metery, crematory or other place) 1 ☐ Burial 2 【 Cremation 3 【 Remova from State Hilltop Service Corp. 1-6-11 Towson, Maryland 4 Donation 5 Qther (Specify) 21. Sign thre of Funeral McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastati disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner in out4 Sequentially list conditions Examine if any tracing to immedia cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 1 Yes 2 No 2 44 Yes 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical examiner? Hospital: Other: 1 🗌 Yes 2 🗔 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) 24 hours a Funeral D Medical 29a. Certifier 🗝 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 00034749 will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DundalK. starrell 2112 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** timore more Office of Month, Age (In yrs. last birthday 8. Date of Birt 9. Birthplace (State or Foreign **Funeral** 1 □**X**M 2 □ F Director NA Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3429-1 21244 Abbie Place USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. African 1 Never Married 2 ☐ Married <u>\$</u> Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: American 3 Divorced 4 Divorced Completed I Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Infant Infant Infant Infant Ith and Mental Hygier 27 is marked other t traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Richard Cotton Shenaah Madgette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3429号 Abbie Place Baltimore, Maryland 21244 Shenaah Madgette-Mother Department of Health Important: If item 27 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Termation 3 Removal from State 01-08-11 Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9 set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Disclores e nonscolenno offi cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confident to the Funeral Director after this confident. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) 2 Hospital Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pendino work? 1 ☐ Yes 2 🔏 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and hitle of certifie License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere 2401 Taimur Chaudhry MD31. Date filed (Month, Day State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ 11:10PM envice 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avenue Baltimore Baltimore 3719 Marmon If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 DM 2 Months Davs Hours Min. (Mohth, Day, Country) 217.20.646 Yrs Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10a State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MD Raltimore Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3719 Marmon Funeral Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Be Completed by Maryland 21215-0036 Specify: DIACK 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4.or 5+) Elementary/Şeconday (0-12) Federal Government Investigative Analyst 2th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carter Helen Madden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly Salaam Wynfield Drive Owings Mills MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Reisterstawn, MD St. Luke Cerneten 10 4 Donation 5 Other (Specify) Vaugin C. Greene Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Pandallstown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician nan uear disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine it any, having to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last this certificate has been signed by the attending physician all director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal dear 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No ☐ Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one, examiner? Hospital 1 Tyes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature at 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V CATON AVE BALTIMORE MD

DHMH 17 Rev 7/2009

State Registrar

AGNES

ST

31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ella Octavia Calhoun 3:05 PM 04, 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gildhrist Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F 82 Months Days Hours Min. Red Lion, PA 162-22-9041 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director Phoenix Baltimore Maryland 1 Yes 2 No 10f. Zip Code 21131 10e. Street and Number 10g. Citizen of What Country? United States 10 Crestmill Court Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) within 7 Lifoam N/A Secretary Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Grace Burkins ပ Rufus Murphree permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10 Crestmill Court Phoenix, Maryland 21131 (Daughter) Debra McGinity 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 7, 2011 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery Parkville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death aucer of Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 ∐ Yes ∠ 9 ☐ Unknown cate has been signed by the page 2 should be detached by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No certificate Yes within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature a of certifie 0071287 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Maryland 21215-0036

Box 68760

P.O.

of Vital

Division

6701 N. Cha

Suite 4105, Balthrare, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 20									
			3. Time of Death							
	Physicia Medic		Maria Nicolas Donn	nnelly			January	7 ^{ay} 2011	8:54 рм	
	Examin		4a. Facility Name (if not institution, give street and number) Gilchrist		4b. City, Town, or Tows (on		1	timore	
	Funeral Director		5. Social Security Number 213-60-1626 6. Sex 1 □ M 2 X F 7. Age (In yrs. last to 1 □ M 2 X F 58	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	°°1952 N	n. Birthplace (State or Foreign 1ary 1 and	
	Iryland I-f show Ied at	ctor	Usual Residence of Decedent	own or Loc					10d. Inside City Limits 1 ★ Yes 2 □ No	
	th the Ma 3a or 28a t be notif	ral Dire	10e. Street and Number 205 Witherspoon Road		10f. Zip Code 21 2	212	10	ng, Citizen of Wha	at Country?	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 【 No If Yes, Give Year or Dates.	If	Vas Decedent of His	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. White	
Baltimore, Maryland 21215-0036	vithin 72 hou piene. er than "natu the Medical		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k life. DC	ent's Usual Occupa kind of work done d D NOT use retired) maker	ition uring most of worki	ng 1	6b. Kind of Busin	ness Industry	
land 2	be filed v lental Hyg rked othe lic event,	To Be	17. Father's Name (First, Middle, Last) George M. Nicolas			18. Mother's Name	e (First, Middle, Ma		agorides	
Mary	d 2 should alth and M 127 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Michael Donnelly-husband			nd Number or Rura			e, Zip Code) 21212	
more,	Page 1 and of Herint: If item int: If item in or othe		20a. Method of Disposition 1 Description 20b. Place 1 Description 20b. Place 20b. Place 20b. Place 20b. Place 20b. Place 3 Removal from State 5 Cember 5 Cember	e of Dispos etery, crem Deme	sition (Name of natory or other place etrios	⁹⁾ 1/11		Oc. Location - Ci	ty or Town, State	
Balti	permit. I Departm Importa any inju		21. Signature of Funeral Service Censee William G. Date	u 22	Name and Addres	s of Facility Ru	ck Towso wson, MD	n Funera 21204	al Home, Inc.	
2	-hysician Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ce of):	er the mode of dying	g, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death	
.09	law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit	edical Examine	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last c	ce of):						
. Box 687	ne death certific / the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pregnanc Other (specify)	у		23d. Date o	,	
ls, P.0	uires that t n signed b ıld be deta	by	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.			ute to the cause of death?	
Division of Vital Records, P.O.	The ate pag	Completed					24a. Was an autopsy perform	prid ed? dea	re autopsy findings available or to completion of cause of ath? Yes 2 \(\sum \) No	
of Vital	To the Hospital or Attending Physician: The within 42 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, pag	e: To Be	27. Manner of Death 28a. Date of injury 28	Bb. Time of	othe	4 □ Nursing Ho	ome 5 Resider 28d. Describe hov		Specify) Habai e	
ision	Attending er death. ector: Afte by the fund	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Month, Day, Year) 28e. Place of Injury - At home building, etc. (Specify)	injury e, farm, stre		Yes 2 No	28f. Location (Stre		or Rural Route Number,	
Div	ospital or hours afte uneral Dir ed filled in	Medical Co	29a, Certifier 1 Certifying Physician: To the best of my knowledge	ge, death c	occured at the time	date and place, an	d due to the caus	e(s) and manner a	as stated.	
4	To the H within 24 To the Fu complete	Mec	(Check 2 ☐ Medical Examiner: On the basis of examination an only one) 3 ☐ Certifying Nurse Practioner: To the best of my kn 29b. Signature and title of certifier	nowledge, o	death occurred at the	e time, date and plac	ce, and due to the o	ause(s) and mann d. Date signed (ner as stated.	
0) phale) /T T	1.5	040		01/08	3/2011	
			30. Name and address of person who completed cause of death (Item 23) APATHI KUMAR G701 N CHARLE			4105 , BA	KLTIMOR	E MD	21204	
	Sta Registra		31. Date filed (Month, Day, Year) JAN 10 2011							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Shirley R. Davis 3:45 P.M January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore n/a 2677 Eagle Street 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🛛 F Hours Min 6/24/1938 Maryland 72 Director 217-34-8609 Usual Residence of Deceden works 10d. Inside City Limits 10h County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State Director or 28a-f sl Baltimore 1 X Yes 2 No MD n/a ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe ns 23a c must b Funeral 21223 USA 2677 Eagle Street and Mental Hygiene.
is marked other than "natural", or items aumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Customer Service Rep Loan Company 0 Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Thelma L. Clements Edward A. Paul pe permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17331 18 1/2 McAllister Street, Hanover, Pennsylvania Earl K. Jarrett, Jr. / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Donation 5 Other (Specify) 1/7/2011 Glen Burnie, MD Glen Haven Mem. Pk. 22. Name and Address of Facility Hubbard Funeral Home, Inc. e of Funeral Service Ligenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final luncer Lung Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury anding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ō Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s autopsy performed?

1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗖 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 🖸 Natural 5 - Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) > 18 Rajapahren D 1/5/11 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209. SMITHAY-5-203, 2835 N.S. Rajapakse, M.D

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Manth

Parks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **9:10** A Physician/ George Raymond Dressel AM 4, 2011 Year January Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 8718 Avondale Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 212-20-3601 1 XM 2 - F Jan. 199, 1923 Maryland 87 **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Parkville MD Baltimore 1 Yes 2 XNo 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral items 23a 21234 8718 Avondale Road **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
Yes 2 \(\sqrt{No} \) Black, White, etc. or ģ 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify. "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Maryland 21215 (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Telephone Company Elementary/Seconday (0-12) College (1-4 or 5+) Service Center Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Irene Short Department of Health and Menta.

In portant: If item 27 is marked via It highly or other them. ၉ George Remier Dressel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11226 McCubbin Avenue-Upper Falls, Maryland Erik Dressel-son 20a. Method of Disposition 20b. Place of Disposition (Name of Jan.14,2011 20c. Location - City or Town, State Carrison Forest Veterans Cenetery 1

Burial 2 □ Cremation 3 □ Removal from State Carrison, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Exans Funeral Charcel and Cremation Services 8800 Harrford Road-Parkville, Maryland 21234 L.MS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached f g Unknown 9 Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed as been signal 2 should b Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed death? certificate 2 No 1 🗌 Yes __ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🗷 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) of person who completed cause of death (Item 23a) (Type, Print) (X Blvd

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011^{Day} Jan 5 Physician/ Jack Albert Dietsch 21:10 PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clinton Prince George's Southern Maryland Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Nov 27, 1929 Months Hours Min. Director 275 24 3837 81 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tyes 2 No Suitland | Maryland Prince George's 10e, Street and Number Citizen of What Country?
United States 10f. Zip Code Funeral 20746 5331 Carswell Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married δ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Airforce/Civilian Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elsie Goldsberry Frederick Dietsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Steve R. Saddler, Sr. (Son) 8215 Northview Court, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Jan 12, 2011 Clinton, Maryland 21. Signature of Furgeral Series ice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MU(39) Ferry Road, Clinton, MD 20735 23a. Priv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s to k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RONCHUGENIC ARCINOMA disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit ベモレかのベノム that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: nse 23c, If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YPOXIA Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 1 Yes 2 No Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pendina work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number Name and address of person who completed of death (Item 23a) (Type, Print) SURRATTS CLINTON State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 2 Date of Death Decedent's Name (First, Middle, Last) Year 5:59A Physician/ 032011 0.1Davis Marguerita Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Country) (Month, Day, Year) 08/03/1935 **Funeral** Days 1 M 2 X F MD 75 220-36-1543 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21060 7575 East Howard Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Lvo. Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2X No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Marguerita Helena Batt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severn, MD 7802 Chevalier Court Mrs. Deborah Wagner / Daughter permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery | 01/10/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Signature of Funeral Service Licenses Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. terio Scherotic Cardio Viscular Onset and Death Drease Immediate Cause (Final Ph_ysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23d. Date of delivery s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Day Year Month in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗹 Yes 2 🗌 No 3 🗌 Probably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 🗌 No 1 Tyes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 X ER/Outpatient 3 IDOA 1 Yes မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: / the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 2 To the 29d. Date signed (Month, Day, Year) and title of certifie 29c. License number 042820

State Registrar

DHMH 17 Rev 7/2009

m.D

3708 mountain Rd. Pasadera, mo 21122

MA

deBoria

Christopher

edress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 | State of Maryland / Department of Health and Mental Hygiene

		- For State			Certific	ate of	Death				Reg. No.			
Physician	1/	I. Decedent's Name (First, Middl	(First, Middle,Last) 2. Date of Death 3. Time of							. Time of Death				
Medical Examin	er	Luke Edwin	Dorsey							January 1, 2011 1945 nrs				
	812	4a. Facility Name (if not institutio 6902 Bonnie Ridge Di								4c. County of Death Baltimore County			ty	
Funeral		5. Social Security Number	6. Sex	7. Age (li	n yrs. last bir	thday)	If Under 1 Year	If Under 2		3. Date of E	Birth (MM	/DD/YYYY	9. Birthp Coun	place (State or Foreign
Director		219-04-9482	1XM 2F	27		Yrs.	Months Days	Hours	Min.	Nov. 9	, 198	33		yland
		Jsual Residence of Decedent												
v any	ľ	10a. State 10b. County		10	c. City, Town	or Locatio	n							0d. Inside City Limits
and show	ᡖ	Maryland Baltim	ore		Balt	imore								1 Yes 2 No
74 Maryland 28a-f show d at once.	Director	10e. Street and Number					10f. Zip Code				10g. Cit	izen of Wh	at Country	y?
7574 ith the Marylan 23a or 28a-f sl		6902 Bonnie Ridg	e Drive Apt	. 202			21209				Į	J.S.A.		
anh with the Maryland items 23a or 28a-f she ust be notified at once	=	11. Marital Status	12. Was De		er in U.S.		Decedent of Hispa s, specify Cuban, I				-0	14. Race White		n Indian, Black,
or ite	[1 X Never Married 2 M	1 Yes	2 X	No					,			Whit	· _
s afte ral",	2		orced If Yes, Give Ye or Dates:		10 I4C-		Yes 2 X No s Usual Occupatio			l. dene	lach	Specify: Kind of Bus		
5-0036 led within 72 hours after death with the Maryland tygene. other than "natural", or items 23a or 28a-f shub. Medical Examiner must be notified at once	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)	ned) Iba.		st of working life. [TOD.	KING OF BUS	5111 6 55/1110	austi y
36 Bin 72 than dical	ᇍ	Elonionally/Gecondary (0.12)	4	1 4 01 01)	Re	search	Assistant				Mer	ritt P	roner	ties, LLC
15-00 filed with Hygiene d other	탉	17. Father's Name (First, Middle,	, Last)						Name (F	irst, Middle		Surname)		
	Re	Scott E. Do	rsey					Caro	lynne	L.	Hayw	vood		
TOFE, MD 2121 ages 1 and 2 should be fi nt of Health and Memtal to Hier and Memtal other traumatic event,		19a. Informant's Name/Relations			1.0		Address (Street					-		Zip Code)
MD ad 2 should hand m 27 is		Scott E. Dorsey /	Father				ot Spring 1							
ore, MC	- 1	20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal f	rom State		of Disposit tory or other	ion (Name of ceme er place)	etery,	C	Date	20c.	Location -	City or To	own, State
Baltimore, permit. Pages 1 a Department of He Important: If ite Important: If ite Imjury or other to	- 1	4 Donation 5 Other Si		om oraco	Hill to	p Serv	ice Corp.		1/10/	11	To	wson,	Mary 1	and
Baltimo permit. Page Department of Important: injury or otd	1	21. Signature of Fundal Service		/			ame and Address o		70		1050) York	Road	
E.E.O.S.	1	cal dy		1		Ruc	k Towson Fi	uneral	Home	, Inc.	Tows	son, Md.	2120	
Physician /Medical	1	23a. Part I. Enter the disease, or failure. List only one cause	or each line.											Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease				ia co	mplicati	ng Al	Lcoh	ol In	toxi	catio	n	Death
	-	or condition resulting in death)	Due to (or as	a consequ	ence of):									
		Sequentially list conditions, if any, leading to immediate	Dianto (or as	g guriswoju	ence of):									-
-		cause. Enter Underlying Cause (Disease or injury that initiated	C											
msit led	X	events resulting in death) Last	Due to (or as	a consequ	ence of):									
frate be executed frate be executed g physician and trans the burial - trans	/Medical	X UNPENDED	d AMENDED	23a	,27 pe	er me	g913 3-	2–11	vt					
8760, ifficate being physicials the burit	¥ [F FEMALE: 3b. Was decedent pregnant in the			of pregnancy		0	Te			23	d. Date of	-	Van
certif	ian	past 12 months?	Live		e of death		aldeath 3 ∟ er (Specify)	Ectopic p	oregnanc	у	ĵ	Month	Da	y Year
Box 68 e death certi	Physicial	1 Yes 2 No 9 Uni	known 9 Unkr	nown		5 Our	el (opeary)							
		Part II. Other significant condit	tions contributing	to death bu	ut not resultir	ng in the ur	nderlying cause giv	ven in Part	l.		_			e cause of death?
ires th	Completed by							_		1Y	es 2	No 3	Proba	bly 4 🗹 Unknown
ords,										24a. Wa aut	s an opsy			psy findings available mpletion of cause of
ecc he lav	Ĕ	-								per	formed?		eath? ✓ Yes	2 No
of Vital Records, ag Physician: The law required this certificate has been so meral director, page 2 should record the state of the sta	Be	25. Was case referred to medica						of Death (C	heck on	y one)				
Vital hysician: this certifi I director,		examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 ER/C	Outpatient	3 DOA	Other 4		Home 5		ence 6 🖢		Scene
J Of ling Ph		27. Manner of Death 1 X Natural 5 Deep	(Mont	e of Injury h, Day,Year)	28b.	Time of In				3d. Describ	e how in	jury occurr	ed	
Sion Attend r death. rector: by the 3	ĕ	= Pen	stigation					es 2 N				-11		
Division pital or Attendiours after death. teral Director: Affilled in by the fu	Certification	dete	ld not be 28e. Pla		/ - At home, t	farm, street	t, factory, office bu	ilding, etc.	28	Bf. Location or Town		and Numbe	er or Rura	al Route Number, City
		(Check billy	hysician: To the be		_									
To the Hos within 24 h To the Fur	Medical	one) Medical Exa	aminer: On the basis and manner		ation and/or	investigation	on, in my opinion,	death occu	urred at t	he time, da	te and p	lace, and d	ue to the	cause(s)
	Ž	29b. Signatule and title of certific	er	\			29c. License							h, Day, Year)
		Clarke	levy,				O.C.N	1.E.			Jar	nuary 2,	2011	
1		30. Name and address of person	, -				ltimore Street	Dali:	ore Mar	24222				
U		Laron Locke MD. A	Assistant Medic	ai ⊑xam egiştrar's		o vv. Ba	umore street	, Dailiii)(JIE, IVIL	2 1223				
Sta Registr	100	JAN 0 7	2011	o ci ai o	1	6	11							
DHMH 17 Rev 1/200	01		-011	Sec. of	0	RIGHNAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruth M. Dietzel 6:12 PM 01 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Good Samaritan Hospital Baltimore 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 542-28-8574 Months Min. 1 M 2 M F Hours November 17, 1928 Oregon Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland N/A Baltimore 1 KXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21214 USA 4301 Walther Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married 1 Yes fire Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) LaCav Monogramming 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Eugene Bish Lucy Anne Lee 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 4303 Walther Avenue Baltimore Maryland 21214 Sandra L. Dietzel/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Parkwood Cemetery 1/5/11 Baltimore Maryland 21. Signature of Funeral Service Licenses 2 Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PULMONARY HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC KIDNEY DISEASE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISEASE ARTERY 24b. Were autopsy findings available prior to completion of cause of CORONARY page 2 autopsy death? 24 hours after death.
Funeral Director: After this certificate 1 ☐ Yes 2 ☑ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 2011 01 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR 601 LOCH RAVEN BLVD BALTIMORE MD 31. Date filed (Month, Day legistrar's Signatu State Registrar

4

00

0

I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DOMINIC Ε. ELLENBERGER January 2011 10:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Health and Rehabilitation Anne Arundel Glen burnie 8. Date of Birth
(Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Days Hours Min. Maryland Director 218-26-4736 1932 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1608 Wall Drive 21122 U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1

XYes 2 □ No
If Yes, Give Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: "natural" Completed 3 N Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry h and Mental Hygiene.

27 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 N/A Factory Worker Domino Sugar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Peter Ellenberger traumatic Genevieve Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1608 Wall Drive Pasadena, Maryland 21122 Donald R. Ellenberger (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. X Burial 2 ☐ Cremation 3 ☐ Removal from State☐ Donation 5 ☐ Other (Specify) 01/10/2011 Pk. Glen Haven Mem. Glen Burnie, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility McCully-Polynia 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death neumonic Physician/ Medical **Examiner** Sequentially list conditions, if any leading to introduct cause. Enter Underlying Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ▼ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation М Accident
Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tit 5159 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Ambalavavav 7845 Oak Oakwood road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 10 Registrar

11-00036 D

Please Type or Print in Rlack Indelible Ink Figure All Copies Are Legible

orsey Ebb		State of Maryland / Department			2011	nnilo			
orsey Ebb		1- For State Certificate			2011	DUILS			
		Registrar	Of Death	Reg	J. No.	3. Time of Death			
Physicia		Decedent's Name (First, Middle,Last)		Month	Day Year	1735 hrs			
Medical Exami	ner	DORSEY EBB JR.		January 1, 2011					
		4a. Facility Name (if not institution, give street and number)	ath						
		2012 Jefferson Street	Baltimore		N/A	1. (0)			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Ars. 18. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign	MARYLAND			
Director		218-60-9860 1XXM 2□F 56	Yrs.	07/22/1	954 Cou	ntry)			
	į	Usual Residence of Decedent							
ga k		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits			
is specific	칟	MARYLAND BALTIMORE BAL'	TIMORE			1 Yes 2 No			
Aaryland 28a-f show	뒳	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Count	try?			
17575 with the Maryland ms 23a or 28a-f she be notified at once	Director	801 WINTERS LANE APT 237	21228		U.S.A.				
s 23a	- 1		Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ	an Indian, Black,			
ath v	<u></u>	1XX Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	White, etc.				
e. 9		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2XX No specify:		Specify: BLAC	K			
0036 // 15 75 within 72 hours after death with the Maryland yiene. her than "natural", or items 23a or 28s-f sho Medical Examiner must be notified at once.	<u>s</u>	or Dates:	edent's Usual Occupation (Give kind	of work done	16b. Kind of Business/In				
2 hou	흵	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use	retired)					
hin 736 e.	亂		ARPENTER		CONSTRUC	TION			
5-0036 led within 72 h dygiene. other than "n	Completed	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma					
He Hy	Bec		į.	VILLIAMS					
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than antic event, the Medical	P P	DORSEY EBB SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number of		per. City or Town, State,	Zip Code)			
shou and y			Winters Lane Apt						
timore, MD 21215 1. Pages I and 2 should be file timent of Health and Mental H retant: If item 27 is marked of y or other frammatic event, if	H		sposition (Name of cemetery,		20c. Location - City or 1				
S 1 2 of H		1 Burial 2XXX Cremation 3 Removal from State crematory of	r other place)						
Pag Pag Inent		4 Donation 5 State Specify.		1-06-11	BALTIMORE,				
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other to		21. Signature of Funeral Service Homese 2	2. Name and Address of Facility WILLIAM C BROWN (COMMUNITY	FUNERAL HO	ME P.A.			
E. E. C. 2		/ / A suplieur	1206 W NORTH AVE	NUE					
Physician		23a. Part I. Betef the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and			
Medical Examiner		Immediate Cause (Final disease a. Methadone Intoxication and Heroin Use							
		or condition resulting in death) Due to (or as e consequence of):							
	L.	Sequentially list conditions, b.							
	<u>=</u>	if any, leading to immediate Due to (or as a consequence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
e executed cian and rial - transit		d.							
executed an and al - transi	Physician/Medical	x UNPENDED AMENDED 23a,27,28a-f	per me g913 3-1	0-11 vt 1	as noted				
50, te be	<u>§</u>	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery				
Box 68760, e death certificate bette attending physical for use as the bu	5	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pre	gnancy	Month Da	ay Year			
x 6 th cer truse	흥	Pregnant at time of death 5	Other (Specify)	- Parketon	İ				
Box 68760, e death certificate but the attending physic ed for use as the but	2	1 Yes 2 No 9 Unknown 9 Unknown							
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be h. After this certificate has been signed by the attending physici chineral director, page 2 should be detached for use as the buin		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		pacco use contribute to the	_			
signe	d by				2 No 3 Proba	abiy 4 Unknown			
aw requirence that been 2 should	Completed			24a. Was ar		opsy findings available ompletion of cause of			
e law e has	튑			perform	ned? death?	2 No			
tal Recian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Che			2 110			
Division of Vital Records, P.O tal or Attending Physician: The law requires that its after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be denactive.	a	examiner? Hospital: 4 Innationt 2 ER/Outpat	Othor 🗔		Residence 6 🗸 Other:	Scene			
Physical directions	입	1 Yes 2 No 1 Impatient 2 Errourpate 27. Manner of Death 28a. Date of Injury 28b. Time			ow injury occurred				
Division of pital or Attending Phours after death. Ineral Director: After titled in by the funeral	ᇹ	1 Natural 5 D (Month, Day, Year)	1 Yes 2 V No						
ctor deat	[at	2 Accident Investigation I d I-I-II I d J	:30pm	unknown		al Route Number City			
after Dir	1								
Spita hours neral	8	4 Homicide PITVate dwe							
Divis To the Hospital or A within 24 hours after or To the Funeral Direc completely filled in by	S S	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control of the control one) 2 Medical Examiner: On the basis of examination and/or investigation.	ccurred at the time, date and place, a tigation, in my opinion, death occurre	and due to the cause ad at the time. date a	(s) and manner as state nd place, and due to the	u. cause(s)			
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	and manner stated.	29c. License number	,	29d. Date signed (Mon				
	Σ	29b. Signature and title of certifier		I	-	in, Day, rear)			
		Mouponer me Skalle	O.C.M.E.		January 2, 2011				
~		30. Name and address of person who completed cause of death (Item 23a)	144 B 301 - C1 - C - C - C - C - C - C - C - C -	MD 04000					
2 V		Margarita Korell MD. Assistant Medical Examiner 900	vv. Baltimore Street, Baltim	nore, MD 21223					
S	tate	31. Date filed (Month, Day Year) 32. Legistrar's Signatur,	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ -ornario 07:40 01 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death University of Mary **Baltimore City** and Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, Year) Jul 14, 1930 079-22-5861 Director 80 Usual Residence of Decedent or 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD **Ellicott City** Howard 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2960 Normandy Dr. 21043 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Fornario Mildred DeFeis injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Diane Lane Ellicott City, MD 21042 Rose Ann Fornario daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Stenger Hill Cemetery Jan 07, 2011 Ft. Loudon, PA 4 Donation 5 Other (Specify) Aura of Funeral 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 any Part 1. Enter the disease, or complications that excised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of): Examiner Tissue Infection Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last the bunal-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 | No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signat sof p son who completed cause of death (Item 23a) (Type, Print) 30. Name and addre SKan 22 South Greene avic 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Margaret 0rene 2011 7:25p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days March 19 1 M 2 X F Hours 85 Director 216-20-4199 MD Usual Residence of Decedent 28a-f show than "natural", or items 23a or 28a-f sho ne Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 Third Avenue M517 21784 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white If Yes Give 3 X Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) administrative assistant clerical is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Herman Heiger Grace Orene Johnson injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Laurie C. LoPresti 35 Carriage Rd., Roslyn NY 11576 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Springfield Cemetery | 1-8-11 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Day Haight of erbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DILATED ISCHEMIC CARDIOMYOPATHY Immediate Cause (Final Physician/ 34PAW disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Day Year 1 Yes 2 19 Unknown g | Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital DOUR HOUSE 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) 121660 62011 non as k. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESMINSTEL MARYLAND 21157 STOKER AVENUT

Registrar

State

31. Date filed (Mo

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00207 State of Maryland / Department of Health and Mental Hygiene George L. Givens Certificate of Death 1- For State Registrar 2. Date of Death edent's Name (First, Middle Last Physician/ Month Day January 7, 2011 1403 hrs Medical Examiner eorge 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (not institution, give street and number) St. Agnes Hospital **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5 Social Security Number 6. Sex **Funeral** Days Hours Director Country) 2 F Usual Residence of Decedent 10d. Inside City Limits III atonsville 1 Yes 2 No or 28a-f show tem 27 is marked other than "natural", or items 23a or 28s-faho traumatic event, <u>the Medical Examiner must be notiffed at once.</u> Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Num ane Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death wi
Department of Health and Mental Hygeine.
Important: If item 27 is marked other than "natural", or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 1 Yes 2 No specify: 4 Divorced If Yes, Give Yaar À 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Be 10 Relationship (Type, Print) 20b. Place of Disposition (Name of 2 Cremation 3 Removal from State Burial ruid Donation 5 Other Specify. 6 21 Si mature of Funeral Service License Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not Physician Vedical Between Onset and Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit Physician/Medical AMENDED UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760, 23d. Date of deliver 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year Live birth 2 Fetal death 3 Ectopic pregnancy Month Day After this certificate has been signed by the attending uneral director, page 2 should be detached for use as it past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes ၉ 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the funeral 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending Division Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City filled in by 3 Suicide Could not be or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number January 8, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month D Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

11-00167 De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eandre Garris		State of Maryland / Department of Health an Certificate of Death	nd Mental Hy		, No. 2011	00153
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
ledical Exami		Deandre Garris		Month January 5,		1450 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Johns Hopkins Hospital Baltimore	or Location of Death		4c. County of Deat	n
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes		8. Date of Birth	(MM/DD/YYYY) 9. Bi	
Director		212-94-4889 10 M 2 F 34 Yrs. Months Day	ys Hours Min.	06/30		puntry) M
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
. ₹		MD Baltimore				1 Yes 2 No
Aaryland 28a-f show i at once,	Director	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Cou	intry?
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		3607 Woodstick Avenue 212	13		USA	
th with	a	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hi If Yes, specify Cuba			14. Race - Amer White, etc.	rican Indian, Black,
ter dea	Fun	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	o specify:		Specify:	act
ours afi ntural'	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa			16b. Kind of Business	/Industry
6 172 hc	leted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life	e. DO NOT use retir	eu)	RUDEL	
5-0036 led within 7 Hygiene. I other than the Medica	Сотр	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	aiden Surname)	/ /)
21215-0036 uld be filed within 72 Mental Hygiene. marked other than t event, the Medical	Be	Malik Salaam	Wan	da Si	eals (We	aters)
D 21 should and Me 7 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street)	et and umber or R	Rural Route Numb	per, City or Town, State	e, Zip Code) 41 21339
등 등 등 등	1	20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of ce crematory or other place)	emetery,	Date	20c. Location - City o	r Town, State
0 % ~ = 1		4 Donation 5 Other Specify: Garden of lan	th 11/1:	3/20/1	KultiMo.	re, Ma.
Baltimo permit. Pag Department Important: Injury or or		21. Signature of Euroral Service Licensee 22. Name end Addres	ss of Facility	ing E.C	4905	YOYCKA
Physician	(,52	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	g, such as cardiac or	r respiratory arres	st, shock, or heart	Approximate Interval
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
المراجين المحا	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				-
	Examiner	cause. Enter Underlying Cause (Disease on injury that initiated				1
ansit		events resulting in death) Last Due to (or as a consequence or): d.				
be executed ician and inial - trans	dical	UNPENDED AMENDED				
	Me	IF FEMALE: 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 25c. If yes, outcome of pregnancy 1 Live birth 25c. Fetal death 3	Ectopic pregnal	nev	23d. Date of deliver	Day Year
Box 6876C death certificate the attending physical for use as the b	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		i Ly	Monar	Day (Ca.
Bo; te death the att	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	in pod I	230 Did tob	acco use contribute to	the cause of death?
ires that the signed by	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.			bably 4 Unknown
rds, requires been sig	Completed			24a. Was ar		utopsy findings available
e law r e has b ge 2 sh	JQ III			autops perform	ned? death?	completion of cause of
of Vital Records, ag Physician: The law require the this certificate has been si neral director, page 2 should be		25. Was case referred to medical 26. Plac	ce of Death (Check of			2 110
Vita	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA			tesidence 6 Othe	er:
ing Ph After 1 funeral		(Month Day, Year)		28d. Describe ho Subject shot	ow injury occurred	
Division In or Attendit rs after death. In Director:	cati	2 Accident Investigation 28e Place of Injury - At home farm street factory office		28f. Location (St	reet and Number or R	ural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		or Town, Sta 2700 Mayfield	ate) Avenue , Baltimore	, MD
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, of the control	date and place, and	due to the cause	(s) and manner as sta	ted.
To th within To th compl	Medical	and manner stated.	nse number	tine time, date a	29d. Date signed (Mo	
	2		c.M.E.		January 6, 2011	
	-	30. Name and address of person who completed eause of death (Item/23a)				
	İ	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore	e Street, Baltim	ore, MD 212	23	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature			OOME	
Regist	_	JAN & V (VIII Anua A. Garana	4		10,000	
DHMH 17 Rev 1/2 OCME 2006	001	ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 11:47 AMM 01 Joan Lee Godman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford <u> 1110 Spalding Drive - Condo</u> . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Davs Hours Min. 10/28/1933 Maryland **Director** 214-30-4776 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21014 1110 Spalding Drive - Condo E Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Margaret Anna Schwartz William Elmer Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21015 203 Forest Valley Drive - Forest Hill, MD Donna A. Ellison (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 01/07/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. E' 21087 11750 Belair Road - Kingsville, Maryland an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CATTOAZ OPTIC Physician/ TOTP disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Tes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Matural 5 Pending in 24 hours after commended the Funeral Director: After the further fu Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 0065015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Rugsell 110 SPACA STR MA TOMORE 3 35 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

OFN

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 810 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Memoria If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Months Hours Min. 1 🗆 M 2 💢 Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at Director Yes 2 No 10f. Zip Code 10g. Citizen of What Country? et and Number Funeral "natural", or items 23a within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic auce. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17, Father's Name (First, Middle, Last) 18. Mot er's Name (First, Middle, Maiden Surname) ationship (Type, Print) 19a. Informant's Name/Re 19b. Mailing Address (Street and Number or Rul City or Town, State, Zip Code Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Part /. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin or complications that caused the death. Do not enter ng, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death the mode of d Immediate Cause (Final Physician/ MINUTES disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death n signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 NO မ 1 🗌 Yes 1 🗌 Inpatient 2 🕽 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Hug line St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene									
			State Registrar 1. Decedent's Name (First, Middle, Las		rtificate of Death		Reg. No. 2011	- 00156		
	Physicia Medi		Isiah Fran	iklin Hemphil	l	2. Date of De Month	Day	3. Time of Death 12:10 A M		
54.40	Examir	ner	4a. Facility Name (if not institution, give	street and number) L AVENUE	4b. City, Town, or Location of Dea		4c. County o	f Death		
K	Funeral Director		01010	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Mir		th y, Year) - 1922	9. Birthplace (State or Foreign Country)		
	rland f show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits		
	he Mary or 28a-1 s notifie	Director	10e. Street and Number	BAL	TIMORE 10f. Zip Code		10g. Citizen of Wh	1 Yes 2 No		
	th with the ns 23a e	Funeral	1503 KENHI	LL AVENUE	212/3		USA			
9000	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer I Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. BLACK		
21215-0036	in 72 ho e. nan "nat Medica	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)	de completed) (Give II College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of wo O NOT use retired)	orking	16b. Kind of Busi			
	at, Hyged	Be C	17. Father's Name (First, Middle, Last)	$\mathcal{J}\mathcal{T}$	EELWORKER 18 Mother's No	me (First, Middle,		CO STEEL		
aryland	buld be fill and Mental marked of matic even	은	ISIAH F. HEI	Mphill, SR.	JAN		:CIVRK	IN		
Mai	2 sho		19a. Informant's Name/Relationship (Ty) MD2e/la HEM	PHILL (WIFE) 19b. Mailin	ig Address (Street and Number or R 3 KENHILL A	4 .4	r, City or Town, Sta ALTIMOR			
nore	Page 1 and 3 nent of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐	20b. Place of Dispos	sition (Name of	Date	20c. Location - C	ity or Town, State		
Baltimore	permit. Page Department (Important: If any injury or once.		4 ☐ Donation 5 ☐ Other Specify 21. Signatu of 5 peral strvice License		Name and Address of Facility	13/2011 AUGHN	GREENG	MILLS, MD FUNERALSCYS		
	8978		23a, Part 1, Enter the disease, or comp	lications that caused the death. Do not ente	4905 YORK RO	AO · BA	TIMORE	MD 21212		
	hysician/	8 9	shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	hty	o or respiratory arr		Approximate Interval Between Onset and Death		
Sec.	Medical Examiner		resulting in death)	Due to (or as a consequence of):	ic kidney	diseas	e	UO .		
	ited J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence on:	ic kidney ,			20		
	oe executed ician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):			-			
8760	ifficate by a physical physica	Medic	IF FEMALE:	d						
). Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hourst after death. Euneral Director: After this certificate has been signed by the attending physicis the filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)		I	3d. Date of delivery Month Day Year		
s, P.O.	requires that the de been signed by the should be detached	by		ntributing to death but not resulting in the ur	_		V	ite to the cause of death?		
ord	w requii	Completed	, , , , , ,	5,1000	e de No	24a. Was a	an 24b. Wei	Probably 4 Unknown re autopsy findings available		
Rec	sician: The law a certificate has t lirector, page 2 s					autop: perfor 1 🗌 Yes		or to completion of cause of th? Yes 2 No		
/ita	siciar s certif lirecto	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	26. Place of Death (Che					
of	ing Phys ffer this uneral dii	ate: T	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?		ence 6 Other (Sow injury occurred	Specify)		
Division of Vital Records,	or Attending P after death. Director: After t d in by the funers	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street	M 1 Yes 2 No et, factory, office			r Rural Route Number,		
<u>.</u> ≧	Hospital or A			building, etc. (Specify) cian: To the best of my knowledge, death or	Coursed at the time, date and place	City or Town		- stated		
:	To the Hosp within 24 ho To the Fune completed fi	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of examination and/or investi Practioner: To the best of my knowledge, de	gation, in my opinion, death occurred.	at the time, date an	nd place, and due to	the cause(s) and manner stated		
	vit To		29b. Signature and tive of centifier	1 MD	29c. License number		29d. Date signed (M			
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Pr						
	State Registra	<u> </u>	31. Date filed (Month, Day, Year) MAR 2 9 2011	32. Registrar's Signature	7110	<u>iaunw</u>	W 1,120	, , , , , ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00143 State of Maryland / Department of Health and Mental Hygiene Rodney Dexter Holloway 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month January 4, 2011 2345 hrs Medical Examiner Rodney Dexter Holloway 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 2925 Woodland Avenue Total If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Hours Davs Director Country) 215-19-0552 36 9-5-1974 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 No MD Baltimore n/a or 28a-f show the Medical Examiner must be notified at once. within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 221.5 FoxBane Square 21209 USA Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Armed Forces? 2 X No Yes Specify: African-American If Yes, Give Year or Dates: 1 Yes 2 No specify: 4 Divorced 3 Widowed ē 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Maintence Laborer permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Medi 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnny Lee Holloway Rosalind Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မှ 19a. Informant's Name/Relationship (Type, Print) Rosalind Holloway/ Mother 2215 FoxBane Square, Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place)
King Memorial Park 1-8-2011 Woodlawn, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 perDVR Brandon M. Wylie 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line.

Combined Effects of Alcohol and Cocaine Use Between Onset and Medical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and per me 1/18/11 G911 EG Physician/Medical AMENDED tem 23a,2 attending physician or use as the burial -UNPENDED law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Vear 1 Live birth 3 Ectopic pregnancy Month Day Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? this certificate has performed? page 2: ✓ Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes ۵ 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 1 X Natural 1 Yes 2 No 5 Pending death. in by the 2 Accident 28f. Location (Street and Number or Rural Route Number, City To the Hospital or Att within 24 hours after de To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 5, 2011 O.C.M.E Dav 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 32. Registra s Signat 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6, 201 I Clyde Ear1 Hendricks January 6:45pm [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sun Valley at Homestead Assisted Living Sykesville Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Birthpia CO **Funeral** 1**X**□ M 2 □ F Months Hours (Month, Day, une 24 521-26-1717 88 Director June Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7150 Sanner Road 21029 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other transmits. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status rmed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes, 2 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clvde Hendricks Florence Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathleen C. Jordan (executor) 7150 Sanner Road, Clarksville, MD 21029 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place)
All County Cremation 1/9/2011 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PUMCNIG disease or condition Medical resulting in death) Du to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in neclaticause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cat has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 24 hours after deatn. **e Funeral Director:** After this certificat. I lated filled in by the funeral director, pag 2/No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2/2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ည 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

Beelah meno

Day,

Imanoel

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO

32. Registrar's Signature

Parke

29c. License number

H53939

218 washington Heights Med Ctry westminster, MD 21157

29d. Date signed (Month, Day, Year)

2011

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan ^{Day} 2011 Month Physician/ Bruce Michael Hartman 2:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ellicott City Ellicott City Health & Rehab Center Howard . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days (Month, Day, Year) Dec 14, 1952 Min 145-46-4714 58 MD Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 3000 N. Ridge Rd. 21043 U.S.A. Was Decedent Ever in U.S. Armed Forceş? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ ☐ Yes Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales **Television Advertising** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Bernard Hartman Mary Elizabeth Ritterpusch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Basehoar Sister 4004 Log Trail Way Reisterstown, MD 21136 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Jan 04, 2011 Atlatic Crematory, LLC Glen Burnie, MD 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the chease, or complications that caused shock, or heart falure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Nda Medical resulting in death) Due to (or as a consequence of): **Examiner** monety Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Yes 2 L No page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed' death? 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗔 No Other 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be the **Director:** Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier Lantiajo Rd Suite

State Registrar Puple 9650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ whor Hall Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Randallstown HIMOV Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** XM 2 DF Min. Hours Country) Director MD Usual Residence of Decedent 28a-f shov 10a State notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a Kincheloe tue. 21207 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 12/acc Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important if item 27 is marked other than "na any injury or other traumatic event ***. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist General Motors 12th grade Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman Harris Lucille Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harris 6705 Kincheloe Avenue, Apt. A Josie G. Raltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Memorial Park 01/08 4 Donation 5 Other (Specify) WindsorMill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Val C. Greene Furerae services 23a. Part 1. Enter the o shock, or heart fai sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line Interval Between Immediate Cause (Fina Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attention to having Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 No 9 Unknown been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page performed 2 1 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 0 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier tifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Carthying Nurse Practionary To the build of my knowledge of the course of the lime, date and place, and due to the cause(s) and manner at etated. (Check 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

01d/aux10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aih

421

anutter

JAN 0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jamuary 201^{Year} Catherine Elizabeth Herche 2025 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carrol1 **Examiner** Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) Aug. 26 1 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 □ **Y**F 220-52-2959 87 923 Director VA Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Svkesville MD Carroll 1 🗆 Yes 2 🗓 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 6207 Long Meadow Drive 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry domestic Elementary/Seconday (0-12) College (1-4 or 5+) homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lucy Ellen Sheets Harmon Buzzard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3336 Uniontown Rd., Westminster, MD 21158 Betty Smith (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1-11-11 Mountain Grove, VA Mountain Grove Cem. 22. Name and Address of FacilityHaight Funeral Home & Chapel . Signature of Funeral Service Licensee Daige Haight & euseut P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metostoti denocovinona Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 ☐ Yes 2 J 9 ☐ Unknown the 9 Unknown detached P.O. by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy nerforme death? Yes 2 N 1 🗌 Yes 25. Was case referred to redical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No ဂ္ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director, After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00059943 612011 phil 30. Name and address of p who completed cause of death (Item 23a) (Type, Print) 295 Stoner 31. Date fled (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00162 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Hornberger, Jr. 01
4b. City, Town, or Location of Death 2011 10:50 02 Vernon Edward /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince Georges Patuxent River Health & Rehab Center Laumel If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F 04/22/1926 Director 214-20-8502 84 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "netural", or items 23e or 28e-f ahow the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No MD Carrol 1 Sykesville Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2053 Harvest Farm Road 21784 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Deportment of Health and Mental Hygiene. Important: If Item 27 ia marked other then "netural", or Item any injury or other traumatic event, the Medical Examinat 1 12 Yes 2 No
If Yes, Give
Year or Dates: 1944-46 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify 2 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hornberger, Sr. Vernon Edward Grace Seabrease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Myrtle C. Gauthier, Daughter 2053 Harvest Farm Road, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/06/2011 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Sepandua 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** HEIMER DEMENTIA /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ate hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probabty 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate hes 1 Tyes 2 11110 1 ☐ Yes 2 ☐ No To the Hoapital or Attending Phyalolen: within 24 hours efter death.

To the Funeral Director: After this certific: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chevrolet drive Ellicotary 2/042 9055 DAVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Allred G. James		1- For State Registrar	Si	tate of	Marylan			nent of F cate of L		nd Me	ntal Hy		Reg. No	20		0016
Physiciar Medical Examin		1. Decedent's Name	,									Date of De Month	Day	Year		3. Time of Death 0829 hrs
incaidal Examin	<u> </u>	Alfred Ge				er)		4b.	City, Town, o	or Location	of Death	January		I1 c. County of D	eath	0029 1115
		4a. Facility Name (if not institution, give street and number) Sinai Hospital 4b. City, Town, or Location of Dea Baltimore										,	N/	A		
Funeral		5. Social Security N	lumber	6. Sex	- 1	Age (In yr	s. last bi		If Under 1 Ye	_	der 24Hrs.	8. Date of B	irth (MN		. Birth oreign	place (State or
Director		212-88-51		1 M	2F	3	37	Yrs.	Months Da	iys Hou	rs Min.	May 2	, 19	973	Cour	ntry) Maryland
any	ŀ	Usual Residence of 10a. State	Decedent 10b. County			10c. C	ity, Towr	n or Location						_		10d. Inside City Limits
E	اءِ	MD		N/A		R ₂	.T+ir	nore								1 Yes 2 No
darylar 28a-f	Director	10e. Street and Nur	mber	11/2	•		<u> </u>		Of. Zip Code	-			10g. Ci	tizen of What	Count	ry?
3a or	3	3020 W. C	Garris	on Av	enue					2121	15			USA		
th will	runerai	11. Marital Status1 Never Marrie			. Was Decede Armed Force		U.S.		ecedent of H specify Cuba			ecify Yes or N Rican, etc.)	0-	14. Race - A White, et		an Indian, Black,
ter dea	2	3 Widowed		1	Yes es, Give Year	2 🔽 No			es 2 N			, ,				ack
ours aff		15. Decedent's Ed		101	Dates:	completed)	16a.	Decedent's	Usual Occupa	ation (Give	kind of w		16b.	Specify: Kind of Busine		
6 172 hc	Completed	Elementary/Seco	ndary (0-12)		College (1-4	or 5+)	1	during most	of working life	e. DO NO	T use retire	ed)				
withir withir present.		12th Gr 17. Father's Name (1 4				Unemp	loyed						N/A	
215- be filed be filed nital Hygerrked oil the		George J		Last)								(First, Middle, Judd	Maider	n Surname)		
		19a. Informant's Na		hip (Type,	Print)	_	19	b. Mailing A	ddress (Stre				mber, C	City or Town, S	tate, Z	Zip Code)
MD d 2 shulth and 27 is		Valerie J		- Mot	her		2	905 G1	antley	y Ave	nue I		ore,	Maryla	and	21215
Baltimore, locamit. Pages I and Department of Heal Important: If item injury or other tra		20a, Method of Disp 1 Burial 2	_	3 🗍 F	Removal from			of Disposition tory or other	n (Name of ce place)	emetery,		Date	20c.	Location - Cit	y or To	own, State
timent trans	Į,	4 Donation 5				M	t. Z	ion Ce	emetery	7	1/12	2/2011	La	nsdown	e,M	ary.land
Bal Bal Depar Impo	1	21. Sign re of Fur	neral Service	Licensee				22. Nam	e and Addres	s of Facili	ty Chatr	ran-Harr	is F	meral H	me	-
Physician	1	23a Part I, Linter the	e Isease, or	complicati	ons that caus	ed the dea	th. Do n	5240 ot enter the r	Neister: node of dying	STOWN , such as o	cardiac or	respiratory an	e, M rest, sh	ock, or heart	2121	Approximate Interval
/Medical	X	failure. List only Immediate Cause (F		_	sthma											Between Onset and Death
2000-0	1	or condition resultin	g in death)	Due	to (or as a coi	nsequence	of):								\neg	
4		Sequentially list cor if any, leading to im	mediate	Due	to (or as a cor	nsequence	of):						_		+	
ted Insit		cause. Enter Under (Disease or injury th	at initiated	C	to (or as a cor		at):								_	
nd nd ransit		events resulting in o	leath) Last	d.	to (or as a cor	isequence	OI).									
68760, certificate be executed nding physician and se as the burial - transit		X UNPENDED		☐ AM	ENDED 2	3a,pt	.II,	27 pe	r me g	911 1	-28-	11 vt			寸	
760, ficate be g physic the bur	1 2	F FEMALE: 3b. Was decedent p	pregnant in th	e 23	Bc. If yes, outo		gnancy						23	d. Date of deli		
		past 12 months?	?	4	Live birth Pregnant	at time of		E Other	death 3 (Specify)	Ectopi	c pregnan	су		Month	Day	y Year
). Box 687(the death certification by the attending placed for use as the physician).		1 Yes 2 N		nown 9					_							
s tetz		Part II. Other signifi		ons cont	ributing to de	ath but not	resulting	g in the unde	rlying cause	given in Pa	art I.					e cause of death?
Records, P The law requires 1 frate has been sign 1 gage 2 should be C	ŀ	_Cocain	e use							···		24a. Was		05-27-29-1	_	osy findings available
of Vital Records, g Physician: The law requir ufer this certificate has been s neral director, page 2 should t					 -				.			autor perfo	osy rmed?		to con	pletion of cause of
tal Rection: The certificate estor, page		25. Was case referre	ed to medical						26 Place	e of Death	(Check or	1 Yes	2N	0 1 🗸	Yes	2 No
Vital hysician this cert directo		examiner?		Hospit	al: 1 Inpa	tient 2	ER/O	utpatient 3		Other ₄			Reside	ence 6 0	her:	
ing Ph After t uneral	12	7. Manner of Death		1 2	28a. Date of Ir (Month, Day	njury (Year)	28b.	Time of Injury	/ 28c. Inju	ry at Work	(? 2	8d. Describe	how inju	ury occurred		
Sion Attend r death. ector: by the f		1 X Natural 2 Accident	5 Pendi	tigation L						Yes 2						
Division of spital or Attending rours after death. Increal Director: Aft filled in by the func Certification:		3 Suicide		not be	28e. Place of (Specify)	Injury - At	home, fa	ırm, street, fa	ictory, office b	ouilding, et	tc. 2	8f. Location (or Town, S		nd Number or	Rural	Route Number, City
0 - 5 >		4 Homicide		1		my knowle	dae des	ath occurred	at the time di	ate and nis	are, and d	ue to the caus	n/s) an	d manner as s	tatod	
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	1	Check only 2	Medical Exan	niner:On t	he basis of ex manner states	amination	and/or in	nvestigation,	in my opinior	n, death oc	curred at	the time, date	and pla	ice, and due to	the c	ause(s)
H 3 H 2	2	9b Signature and ti	itle of certifier	7/	0/	/m	940	7	29c. Licens				29d. [Date signed (Month,	Day, Year)
	1	/webs	Hal	En	4/ell				O.C.	M.E.			Jan	uary 3, 201	1	
1	3	0. Name and addre				•	,	900 W P	altimore 9	treet P	altimore	e, MD 2122	23			
State	3	1. Date filed (Month		, (33)01						-		., IVIL 2 122				
Registra		JAN	0 7 201	1 /	32. Registr	1.	400	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month I-RANK DACHIM 27M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13901 Resin Court Prince George's Bowie . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Year) 928 1 M 2 □ F Months Days Hours Min. Mar 20, **Director** Minnesota 053-22-0614 82 Yrs. Usual Residence of Decedent show 10a. State 10b. County must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 28a-f Arizona Pima Tucson X Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1515 Entrada Segunda 85718 United States items ; filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Black, White, etc. 1 X Yes 2 No ō þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1950-79 1 ☐ Yes 2X No Specify: "natural" 3 XWidowed 4 ☐ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Soldian Lieutenant Colonel US Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ٩ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Hildegard Marshall Anthony Joachim Gladys Olson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9922 Pebble Beach Drive Santee, CA 92071 Susan Barbara Joachim/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/6/2011 Woodbine, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 7
BEverly L. Heckrotte, P.A. Clarksville, M00957 21029 MD 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Stog Congestine Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a cons uence of) Examiner γηρς Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 S autopsy page performed' certificate 2 🗌 No Yes 2- No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2. No Other: မှ 1 Tes HOME 4 Nursing Home 5 Residence 6 Otb 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pendina ☐ Accident Investigation M 1 Tes 2 No neral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 36 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 MAR M 44 EN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar 7601

OSLER DRIVE

TOWSON, MARYLAND

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DICKINSON,

M.D.

32. Registrar's Signature

8

GRETCHEN

31. Date filed (M

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 1 perpHYS, G911, 1/13/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

Bertha Elizabeth Johnson
Lohnson 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:04 15/ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STURIE ente 1270 1910 Raltimore If Under 1 Year | If Under 24 Hrs 5. Social Security Number, 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Min 1 □ M 2 1 □ F Months Days Hours 96 Director 215-01-0915 May 4,1914 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits al", or items 23a or 28a-f show Director Middle River 1 ☐ Yes 2 ☑ No Baltimore MD 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 21220 United States 1300 Windlass Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced "natural", White The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Stores Salesperson 7 Years permit Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lin ury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Wittig George Albert ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 Parkland Drive Bel Air, Maryland 21015 Mr. Raymond Kramer (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National Cem. 1/5/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21222 Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or one shock, or hea the man list only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eumani r disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 □Yes 1 ☐ Yes 2 🖺 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient 2**X** No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Medical 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

5284 L E

edistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:15 PM Month 3, Year 20 January William Lawrence King Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Dulaney Valley Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min Month Day Y Year) 1928 82 Director 217-24-9681 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21234 United States 2218 Loyelles Glen Rd. Unit D 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 ★ Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 1 Yes 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechanic Balto., Co. Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John King Julia Lockard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) King /Wife Mary 2218 Loyelles Glen Rd. Unit D Parkville, MD 2123 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Jan 05 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility

Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 \square Yes should icate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate Yes 2 K 1 \sum Yes 2 No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗌 Residence 6 🛣 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License number of person who completed cause of death (Item 23a) (Type, Print) JONES,

State Registrar

ANUARY

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

2. Registrar's Signature

TIMONIUM, MD 21093

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 10-25 MM 2011 January 3, Mary M. Kessler 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Heritage Center Dundalk If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days 1 M 2 F Yrs 90 May 12, 1920 Pennsylvania 194-10-8500 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1⊈Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21224 540 South Lehigh Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 If Yes, Give 2 **X**No 1 Never Married 2 Married 1 ☐ Yes 2 ANo Specify: 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care 10 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Unk Yanzo Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 540 South Lehigh Street Baltimore, MD 21224 Wayne Kessler /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Jan 05 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 9717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LOS Immediate Cause (Final EFICILLE disease or condition resulting in death) 23d. Date of delivery Day Month Vear

Physician /Medical Examiner

> the ģ

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f si Examirar must be notified

Director

Funeral

ģ

Completed

Be

ျှ

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene.

Department of

marked other

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Vital

Division of

Hospital or Attending Physician:

Seque if any, cause. Cause that ini resultin

leading to immediate Enter Underlying (Disease or injury tiated events	ARTERIO-SCLEROTIC CARDIO VI
nj in death Last	d.

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 □ Yes 2 No
9 Unknown

ii you, outdoine or programmy
1 ☐ Live birth 2 ☐ Fetal dea
4 Pregnant at time of death
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 ☐ Ectopic pregnan 5 ☐ Other (specify)	icy	

Did tobac	co use con	ribute to the cau	se of death?
1 □ Yes	2 No	3 ☐ Probably	4 🗌 Unknow

25. Was case referred to medical
examiner?

		autopsy performed
_	26. Place of Death	(Check only one)

			ngs available
		mpletion	of cause of
	eath?		
1 [□Yes	2 🗆 No	

2. No
Death
al 5 □ Pe

	но	spital:	1 Inpatient	2 🗆	ER/C	utpatie
ending vestigation			Date of Injury (Month, Day, Y			Time o Injury

Hospital:

ıt	3 □ [AOC	Otner:	4 Nursing H	ome	5 🗌 Resi	dence
:		28c.	Injury at Work?		28d.	Describe	how in
	M		1 TVes	2 🗆 No			

death?	2 □No	

1 Matural	5 Pending
2 Accident	investigation
3 Suicide	6 Could not be
4 Homicide	determined

28a.	Date of (Month)	Injury Day, Year

and manner stated.

:	28c. Injury at Work?	
М	1 □Yes	2 □No

 - 1	Ι.		•	_		_		 		
			_	_						
_	П	0.1			_					

4	Homicide
200	Contifier

					1				
28e.	Place buildi	of ng	Injury - etc. (S	At I	home,	farm,	street,	factory,	offic

28f.	Location	(Street and	Number	or Rural	Route	Number,

28d. Describe how injury occurred

29a. Certifier	
(Check on one)	ly 2
	- 1

	an: To the best of my knowledge, death occurred at the time	
Medical Examine	: On the basis of examination and/or investigation, in my opin	nion.

t the time, date and place,	and due to the cause(s)	and manner as stated.
n my opinion, death occur	red at the time, date and	place, and due to the cause(s)

24a. Was an

9b. Signature and title of o	certifier
1 FALL	Mathry
	1

Kmo	
-----	--

01710	29c.	License r	number	1	6	(
-------	------	-----------	--------	---	---	---

29d. Date signed (Month, Day, Year)	
JANUAR 03, 20	
0111001111	_

Cto	٠.
Sta	ιe
Registr	aı

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Year Raoul Fredrick Kulberg January 1:05 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days 1 **XX**M 2 □ F Hours Min (Month, Day, Year) **Director** 08 436-32-1498 1930 Dec. 4. Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No DC District of Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a oner must be Funeral 3916 McKinley St., N.W. 20015 United States "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 XMarried 1 Yes 2 No If Yes, Give X Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Universities Reference Librarian $5\pm$ Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Fredrick Kulberg Florence Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eve Anne Kulberg (wife) 3916 McKinley St., N.W., Washington, DC 20015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan Date 5. 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2 Large sacral decub, WBC Sequentially list conditions, it any, healing to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to jor as a consecuence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit Hypotension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CLL, Leukopenia, Paralysis 2 to West Nile Virus, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed Encephalitis, Tracheostomy, pressure ulcers, prostate Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No cancer, P.E., U.T.I. 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည eral Director: After this filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69916 1/2/11 of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, MD 20910 Niok Wright, M.D. onth, Day, Year) 31. Date filed (I 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH,G912,2/24/2011,WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2011 Physician/ 1< raft Month Evelyn 5:30 1 Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Season's Hospice Baltimore Randallstown 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months Days Hours Min 90 MD Director Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FLOrange Orlando 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? USA 10e. Street and Number 3218 32810 Funeral Drake Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. ò 1 Never Married 2 Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes. Give Completed 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Malden Surname)
Esther Wrightson 17. Father's Name (First, Middle, Last) Charles Jesse Elwood Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny M. Breeding / Daughter 1267 Maple Avenue, Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 1/7/2011 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final End. Stage (OPD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L g ☐ Unknown g Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 sl autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSROJapahseM.O 1/5/11 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 703, Baltimore, MD. 2120 9. N. S. Rajapakse, M.D 2835 SMITH AV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 7 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 1:46 A M **Physician** Nummer 03 Januar 2011 anor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 05/21/1970 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Days 40 151-70-2072 NJ Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b County т 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21207 USA 3006 Fairview Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must is once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛚 No Specify: If Yes, Give 2 Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Entertainment Actress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vallery Ann O'neal Lloyd Bryant Long မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3006 Fairview Rd Paltimore, MD 21207 Geoffrey Long-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery Baltimore, MD 1 .06 .2011 21. Catura of Funeral Service John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician endocarditis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live birth 2 Fetal death
Pregnant at time of death in the past 12 months? Month Dav Year 1 Yes 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 No 3 DDA 2 ER/Outpatient 5 Residence 6 Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Certification: 5 Pending investigation 24 hours after death.

Funeral Director: After Injury 1 Yes 2 🗌 No 2 Accident 3 Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES -000 January 03, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Houston

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CARL LOUIS LAUMAN, JR. Month 2011 1:20P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Baltimore Good Samaritan Hospital 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth **Funeral** 1**X** M 2 □ F 90 Director Yrs. 1920 Marvland 710-09-5608 Usual Residence of Decedent it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director White Hall 1 Yes 2 X No Maryland Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21161 19443 Ensor Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 K XYes 2 No Black White etc. δ 1 Never Married 2 Married XXYes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Year or Dates. WW 11 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Patapsco & Back River College (1-4 or 5+) Elementary/Seconday (0-12) 12 yrs. Railroad Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elizabeth Snyder Carl Louis Lauman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #215 White Avenue Baltimore, Maryland 21206 David L. Lauman (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Gardens of Faith 1-8-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Lassann Funeral Home 7401 Belair Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Problem of the Model of the Cardiac Tark Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to lor as a conse Juence of: cause. Enter Underlying attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) signed by the a d be detached for 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsv death? performed 1 Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours a er death. Funeral Director Af Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number
USFS70 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JAN 1 0 2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Joseph I	_ynch
	1-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

0	\cap	1	1		\cap	Į.	7	1.
/	0		į.	0	U		-/-	
E-em	_							

		1- For State Registrar		Cen	tificate of	Death			Rea	. No.		
Physici			le,Last)						te of Death		3. Time of Death	
Medical Exami	iner	Michael	Joseph L	.ynch				Jar	nth nuary 3, 2	Day Year 2011	1002 hrs	
		4a. Facility Name (if not institution 9000 Satyr Hill Road	on, give street and n	umber)	4	b. City, Town, or Towson	Location of	f Death	h 4c. County of Death Baltimore County			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	r 24Hrs. 8. D	ate of Birth	(MM/DD/YYYY) 9.	Birthplace (State or			
Director		220-62-4982	1 M 2 F	58	Yrs.	Months Day	s Hours		3/08/	1For	eign Country) Maryland	
en y		Usual Residence of Decedent 10a State 10b. County		10c. City,	Town or Location	on					10d. Inside City Limits	
È.,		Maryland Bal	timore		F	Parkvill	A				1 Yes 2 X No	
rylan	cto	10e. Street and Number	01:1101 C			10f. Zip Code			100	. Citizen of What C		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Inst: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	2624 Pearwo	od Court			Tot. Zip oodo	212	34	log	US	•	
with with se no	Funeral	11. Marital Status		cedent Ever in U.S	6. 13. Was	Decedent of His	_		es or No-		erican Indian, Black,	
death riter	nue	1 X Never Married 2 N	arried Armed F	orces?	If Ye	s, specify Cubar	n, Mexican,	Puerto Rican,	etc.)	White, etc		
after after ner n	by F		orced If Yas, Give Ye	ar	1	Yes 2 X No	specify:			Specify:	White	
ours :		15. Decedent's Education (Spe		de completed)	16a. Decedent	s Usual Occupa	tion (Give k	ind of work do	ine 1	16b. Kind of Busines	ss/Industry	
6 172 h	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working life	. DO NOT L	use retired)			D 1 C .	
within jene.	Completed	12		4	u c	ırdener					Park Service	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be C	17. Father's Name (First, Middle Robert C. Lynd						s Name (First, thleen		niden Surname)		
212 Ild be Menta marko	To B	19a. Informant's Name/Relations			10h Mailine	Addross (Street				er, City or Town, St	1.7.0	
MD 3 d 2 shou th and 3 n 27 is umatic	-	Mr. Robert C. L		ther		Queens				timore, M		
e, M l and 2 Health litem 2'		20a. Method of Disposition		20b. P		ion (Name of cer	•	Date		20c. Location - City		
Saltimore, permit. Pages I an Department of Hea mportant: If iten		1 Burial 2 X Cremation		rom State Hill	ematory or other	erplace) Prvice C	orn	01 /08 /		Towson,	• • • • • • • • • • • • • • • • • • • •	
·= 8291	- 2	4 Donation 5 Other S 21. Signature of Funeral Service	Decify:	11,11		ame and Address	·				•	
Balt permit Depart Impor		Obsandua				nard J.	,			305 Harfo		
Physician		23a. Part I. Enter the disease, or	complications that of	aused the death.	Do not enter the	e mode of dying,	such as ca	rdiac or respir	atory arrest	t, shock, or heart	MD 21214 Approximate Interval	
/Mudical		failure. List only one cause Immediate Cause (Final disease	on each line.	theroscl plicated	erotic	Cardiov	ascula	ar Dis	ease		Between Onset and Death	
Examiner		or condition resulting in death)		consequence of)		o chermi	<u>a</u>					
		Sequentially list conditions,	b									
	ine.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of)	:							
	Examine	(Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	a consequence of)	1				_			
cuted nd transit	ũ		d									
1760, ficate be executed g physician and the burial - transit	n/Medical	X UNPENDED	AMENDED	23a,27	,28a-f	per me	g911	1-28-1	l vt			
8760, ificate be up physic sthe burn	/Me	IF FEMALE:		outcome of pregna						23d. Date of deliv	ery	
Sox 687 leath certifide attending for use as t	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	oirth nant at time of dea	th	al death 3 [Ectopic	pregnancy		Month	Day Year	
Box 68 le death certi the attendin led for use a	Physicia	1 Yes 2 No 9 Un	known 9 Unkn		tn 5 Oth	er (Specify)						
O. By trucke de by the ached f		Part II. Other significant condit	1 —		sulting in the un	derlying cause g	given in Parl	t I. 23	Be. Did toba	acco use contribute	to the cause of death?	
Division of Vital Records, P.O. talor Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detach.	b S								1 Yes	2 No 3 P	robably 4 🗸 Unknown	
ords, w requir s been s should	Completed	<u> </u>						24	a. Was an	24b. Were	autopsy findings available	
e law	臣							— l	autopsy performe		o completion of cause of ?	
ital Recician: The scertificate rector, page		25. Was case referred to medica	, -,	<u></u>					✓ Yes 2	No1 ✓	Yes 2 No	
fital sician is cert lirecto	Be	examiner?	Hospital:	Inpatient 2 E	ER/Outpatient		Other -	Check only on		id 0 d ou		
of Viing Physi	5	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of In		ry at Work?			esidence 6 🗹 Oti	ner: Scene	
ision of Vi Attending Phys or death. rector: After this by the funeral di	뎚	1 Natural 5 Pend	(Month	n, Day,Year)		i Ii.	res 2. X I			• •	sed to cold	
r Atter der der irecte	ig ig			-3-11 te of Injury - At hor	fd 9:40 me, farm, street	am		- 1				
Divi	Certification:	oulcide out	d not be (Specify)	e of Injury - At hor outside nursery	e in wo	oded are	ea of	Par	Town, Stat	e 8alto	Rural Route Number, City, atyr Hill Rd. Co, Md. 2123	
Hosp 24 hou Funer rely fi		20a Cadifias	hysician: To the be		e, death occurre	ed at the time, da	ate and plac					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Medical	one 2 Medicai Exa	miner: On the basis	of examination and	d/or investigation	on, in my opinion	, death occ	urred at the tir	ne, date an	d place, and due to	the cause(s)	
F 3 F 8	Me	29b. Signature and title of certifie		nateu.		29c. License	e number		2	29d. Date signed (A	fonth, Day, Year)	
		(Calula	MA			O.C.I	M.E.			January 4, 201	1	
		30. Name and address of person	who completed cau	se of death (Item 2	23a)							
2			ssistant Medica			timore Stree	t, Baltimo	ore, MD 21	223			
	ate	31. Date filed (Month, Day, Year)		strer's Signature	0	Red						
Regist			7 0011		20 4 4							

ORIGINAL

Amend #7, per FH g911 1/10/11 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 900AM **Physician** Elizabeth Irene Lerch 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FRANKLIN Baltimore Square HUSFITC 1 ROSecia If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 06/12/1927 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F 220-20-9401 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 Mo MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 Woodside Avenue 21234 U.S.A. **Funeral** 12. Was Decedent Ever in U.S. Armed Forces?
1 [] Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ 61.2ab Specify 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Tax & Title 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Adolph Rometsch Elizabeth Gecke1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3330 Woodside Avenue. Parkville. MD 21234 Sara Mullin, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 01/08/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck. Inc. 200 Mexandria 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due t (as a consequence of): /Medical Examiner Branchitis Sequentially list conditions, if any, leading to immediate cause. Enter the desired Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Atelectasis sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death. Per Funeral Director: A pletely filled in by the fu death. 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) adrien 8. yamusen, MD, PhD D0070158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV 4000 FRANKLIN SQUATE DR. Ballo md 21237 2. Janvier. Adrien 32. Registrac's Signature 31. Date filed (Month, Day, Year) State

Registrar

9

Deneura

11-00096 John Levinski Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onn Levinski	.1		- For State Registrar	State of Mar	/iand /		tificate of		na ivien		Re	g. No. 20		00176
Phys P∽dical Exa		_	1 Decedent's Name (Firs							2.	Date of Deat Month January 3,	Day Yea	ar	3. Time of Death 1140 hrs
			4a. Facility Name (if not in	nstitution, give street and treet. Conklin				b. City, Town, Baltimore	or Location of	of Death	, .,	4c. County	of Death	
Funer		Ħ	5. Social Security Number				st birthday)	If Under 1 Ye	_		B. Date of Birt	h(MM/DD/YYY)	7) 9. Birti Foreigr	nplace (State or
Direct	Or	ļ	213-68-8603 Usual Residence of Dece		F [55	Yrs.		iys Hours	S I IVIII I.	01/02	/1956		ntry) Maine
v any		l		County	1	loc. City,	Town or Locati	on				-		10d. Inside City Limits
Maryland 28a-f show	once.	į	Maryland 10e. Street and Number	N/A		Balt	imore	L 406 7:- 0 - i-			Li	0.00		1 Yes 2 No
he Mar	be notified at once.	9	220 S. Conkl	lin Street				10f. Zip Code 21224				og. Citizen of W Jnited S		-
hours after death with the Maryland natural", or items 23a or 28a-f sh	st be not	L	11. Marital Status 1 X Never Married 2		Decedent Ed Forces?	_		L s Decedent of F es, specify Cub					e - Americ e, etc.	an Indian, Black,
after de	ner mu	by Fu		Divorced or Dates:		∑ No	1	Yes 2 X	lo specify:			Specify:	Whit	:e
hours."	Exami	ted t	15. Decedent's Education Elementary/Secondary	on (Specify only highest (grade comp e (1-4 or 5-			t's Usual Occup ost of working li				16b. Kind of Bu	usiness/Ir	dustry
0036 within 72 giene.	the Medical Examiner	Completed	8	(0 12) Conleg	0 (1-4-01-0		Clerk					Wareho	ouse	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than	t, the	Be င	17. Father's Name (First, John P. Lev							,	irst, Middle, M Czarne	laiden Surname	•)	
212 ould be d Ments	tic event,	၉	19a. Informant's Name/Re	elationship (Type, Print)		-	400	•	eet and Nun	nber or Rura	al Route Num	ber, City or Tow		
	rauma	- 1	Patricia Sha 20a. Method of Dispositio			20b P		 Conkl ition (Name of contract) 			Baltimo Bate	ore, Mar		nd 21224
Baltimore, MD 2: ormit. Pages I and 2 should Department of Health and Minportant: If item 27 is m.	other 1		1 Burial 2 X Cr	remation 3 Remova	al from Stat	e c	rematory or oth						•	e, Maryland
Baltimo permit. Page: Department o	jury or	t	4 Donation 5 0 21. Signature of Funeral			NOI	22. N	ame and Addre	ss of Facility	y				e, maryranc
ம் ஐத்த Physicia		_	23a. Part I. Enter the dise	ease, or complications the	at caused t	he death.	4()	IS. Ch	ester.	Stree	t Ralt	nes P.A.	Mars	land 21231 Approximate Interval
/Medic Examin	-	4	failure. List only one Immediate Cause (Final or or condition resulting in d	e cause on each line. disease a. Chronic	Obstruct	ive Pul	monary Dis		9,		- F			Between Onset and Death
			Sequentially list condition	ns, b										
		를	if any, leading to immedia cause. Enter Underlying (Disease or injury that ini-	Couse C.									171	
uted	ransit	Medical Examiner	events resulting in death)) Last Due to (or a d.								- 1		
50, ite be exec hysician ai	burial - transit	<u>ğ</u> [UNPENDED	X AMENDE	_D 4a	per 1	me g912	2-7-11	vt					
: 68760, certificate be executed nding physician and	as the b		IF FEMALE: 23b. Was decedent pregnate past 12 months?	ant in the	es, outcom e birth	e of pregn		tal death 3	Ectopi	c pregnancy	/	23d. Date of Month		ay Year
Box 687(e death certifica the attending pl	for use as the	Physician/N	1 Yes 2 No 9	I I I I I I I I I I I I I I I I I I I	egnant at ti iknown	me of dea	ath 5 Oth	ner (Specify)				Î		13
P.O. Es that the egned by th			Part II. Other significant	conditions contributing	g to death	but not re	sulting in the u	nderlying cause	given in Pa	art I.				he cause of death?
15, P	uld be	ted	Schizophrenia				· · · · · · · · · · · · · · · · · · ·				1 Yes			ably 4 Unknown opsy findings available
of Vital Records, P.O. Box ig Physician: The law requires that the death after this certificate has been signed by the atte	ge 2 sho	Completed by									autop: perfor	sy i	prior to co death?	ompletion of cause of
tal Rection: The certificate	director, page	B C	25. Was case referred to examiner?					26.Pla		(Check only	y one)			
of Vid Physic ter this		유		No Hospital: 1	Inpatien		ER/Outpatient 28b. Time of Ir		jury at Work			Residence 6		Scene
	the fun	틽	1 Natural 5	Pending Investigation	ate of Injur	ar)		· · _	Yes 2	. 1		on many occur.		
Division tal or Attendii rs after death.	filled in by the	Certification:	3 Suicide 6			ıry - At ho	me, farm, stree	t, factory, office	building, et	tc. 28	f. Location (S or Town, Si		er or Rur	al Route Number, City
To the Hospital within 24 hours To the Funeral	completely fil	Medical C		fying Physician: To the cal Examiner:On the bar	best of my									
T Kiti	99	Me	29b. Signature and title or	and mann of certifier	or stateu.				nse number			29d. Date sign		th, Day, Year)
			UMODO	f parean who complete it	20102 25 2	oth /lt	220)	0.0	C.M.E.			January 4,	2011	
100			 Name and address of Ana Rubio MD. 	Assistant Medic		•	•	more Stree	t, Baltimo	ore, MD 2	21223			
Reg	Sta gist		31. Date filed (Month, Da	y, Year) 32 1 0 2011	egistrar'		1. Sec	Kel						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 January 12:30 PM Allen Lewis Livick, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 3443 Augusta Rd. Carroll Manchester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Y **X**[X] M 2 □ F Months Days Hours Min 224-07-9193 91 Virginia **Director** 919 Aug. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits Director 1 Yes XX No MD Carroll Manchester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3443 Augusta Rd. 21102 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. þ 1 Never Married XXMarried 1 ☐ Yes XXNo Specify: If Yes, Give Year or Dates. WW II White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Edgewood Arsenal Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Engineer Chemical Company Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Morton Livick Florence Anna Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 3445 Augusta Rd. Manchester, MD 21102 Linda Taylor / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Evergreen
Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 4 Donation XXOttEmbeombment Jan.10, 2011 Finksburg, MD 21. Signature of Fundal Service Licens 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. Inn 3296 Charmil Dr. Manchester, MD 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in n each line. Approximate Interval Between Immediate Cause (Final Onset and Death YROSTATE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after deatl 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined e Funeral i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) x

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

JAN 0

son who completed cause of death (Item 23a) (Type, Print) 2300 DULA

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Flease	State of Marylan				•		agibie.		
		For State	State of Marylan	•	rtificate of Deat			2	0.11	00178	
		Registrar 1. Decedent's Name (First, Middle, Last))		Tillicate of Deat		2. Date of Deat	eg. No.	0 1 1	3. Time of Death	
Physicia Medic		Leona, Leddo	21				Month O/	Day	(2011	12:412 11	
Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, o						4c. Cou	unty of Death	1	
Funeral		5. Social Security Number 6. Sex	yland Medical (7. Age (In yrs. 10	ast birthday)		nder 24 Hrs.	8. Date of Birth	<u> </u>	9. Birth	nplace (State or Foreign	
Director		220 32 3,30	□M 2 🕸 71	Yrs.	Months Days Hou	ırs Min.	1 0 – 1 – 1	939	VA	ntry)	
and show at	or	Usual Residence of Decedent 10a. State 10b. County		y, Town or La	ocation		-			10d. Inside City Limits	
Maryla 28a-f s	Director	MD Carrol	11		Westmin	ster				1 ☐ Yes 2 🔀 No	
th the	alD	10e. Street and Number 226 Gorsuch Rd.			10f. Zip Code 211	E 7		-	of What Cou	untry?	
ath wi	Funeral		12. Was Decedent Ever in U.S	113	Was Decedent of Hispanic			JSA	Race - Ameri	ioon Indian	
ter de , or it	Completed by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cuban, Mex	xican, Puerto F	Rican, etc.)	E	Black, White	, etc.	
ours af tural" al Exa		3X Widowed 4 □ Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a. D			1 ☐ Yes 2 🖾 No Specify:			Specify: white			
72 hc an "na Medic	mple	(Specify only highest grad	de completed)	(Give	dent's Usual Occupation kind of work done during r OO NOT use retired)	most of workin	ng		of Business In	ndustry	
withir giene ner tha t, the		Elementary/Seconday (0-12)	College (1-4 or 5+)	Fac	tory Worke	r		Fact	cory		
e filed ntal Hy ed ott	To Be	17. Father's Name (First, Middle, Last) William F. Hamm				18. Mother's Name (First, Middle, Maiden Surname)					
d Mel d Mel mark matic	' I	William F. Hamm Edith Robinette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To							01.1.7	0-10	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		William J. Ledd			Gorsuch R						
of He of He If item or othe		20a. Method of Disposition 1 Burial 2 CCremation 3 I	Removal from State Co	emetery, crei	osition (Name of matory or other place)	!		20c. Locati	ion - City or T	Town, State	
it. Pag rtment rtant: njury c		4 Donation 5 Other (Specify)	Sou		arroll Cre	i .			ield,		
permi Depar Impor any ir		21. Signature of Juneral Service Licensee 122. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157							ome 21157		
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	lications that caused the death	h. Do not ent	ter the mode of dying, such	h as cardiac o	respiratory arre	st,		Approximate Interval Between	
Physician/	iner	Immediate Cause (Final disease or condition				hage				Onset and Death	
Medical Examiner		Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):					J			2 weeks	
ψ.										a vocch-	
be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	с							_	
be executed sician and burial-transi	cal E	resulting in death) Last	Due to (or as a consequ	ience ot):							
icate t phys s the l			d								
eath certificate be attending physicater to a for use as the t	Physician/Med	Zob. Was decedent pregnant	ncy Il death 3	☐ Ectopic pregnancy		23d.	23d. Date of delivery				
e death the att hed for		in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	5 Other (specify)			Month Day Year					
ires that the dea signed by the a ld be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?				
requires been sign should be	ted b						1 □ Y€	1 Yes 2 No 3 Probably 4 Unknown			
law recast last be 2 shc	te: To Be Completed by							У	24b. Were autopsy findings available prior to completion of cause of		
sician: The law is certificate has t								ned? No	death?	2 X No	
siciar certif irecto		examiner? Hospital: W					eath (Check only one) Nursing Home 5 Residence 6 Other (Specify)				
ig Phy ter this neral d		27. Manner of Death 28a. Date of injury 28b. Time of injury 28b. Time of injury 28c. Date of injury 28b. Time of injury 28c. Date of injury 28c. Date of injury 28c. Date of injury 28c. Date of injury 28c. Date of injury 28c. Date of injury - At home, farm, stouilding, etc. (Specify)			e of 28c. Injury at 28d. Describ			e how injury occurred			
tendin leath. tor: Af the fu	Certificate:				work? M 1 ☐ Yes						
l or At after o Direct d in by	Medical Cert							n (Street and Number or Rural Route Number, own, State)			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy, completed filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier (Check (Check 2							ted.		
the Fithin 24 the Fithin 24 the Fither Fithe	Me		e Practioner: To the best of my			date and place	e, and due to the	cause(s) and	d manner as s	stated.	
≓ ≽₽8		De la constitución de la constit	1		AU4117	6435	100552/	ou. Date Sig	gned (Month,	, vay, rear)	
11		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	AUCII70 Street Su	4	- 40	1,00	- ' 	1 h	
b'		Evan Lewis 31. Date filed (Month, Day, Year)	22 5. 614	ene S	Street Su	Le 12	-1) Bo	Hun	012 1	MI)	
Stat Registra		JAN 0 7 201	1 Alegistrar's Signat	ba	ale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 05. Physician/ 2011 6:25 AM FLORENCE P LAYTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCHRIST HOSPICE CARE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months Hours (Month, Day, Year) 07/27/1918 92 MD **Director** 218-03-0151 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Examiner must be notified at Director 1 Yes 2X No MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21208 7 SLADE AVENUE, APT. 103 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed WHITE permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ MORRIS POLANSKY BESSIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SLADE AVENUE, APT. 822, BALTIMORE, MD ROBERT LAYTON/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTONE CHIZUK 01/06/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed by the attending physician and tached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Day Year in the past 12 months?
1 Yes 2 No Month signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 Y No 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should t Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOS PUL ၉ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 2 Accident 5 Pending 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-Charles ST DW DON MD 6701 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 15pm 0 Medical (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** wars If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Number **Funeral** (Month, Day, Year Mar 08, Min. 1 M 2 F Months Days Hours Country)
Illinois 66 194 Director 332-36-4138 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral with United States 21218 3900 Loch Raven Blvd rral", or items? permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced White th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Telephone Elementary/Seconday (0-12) College (1-4 or 5+) Communications 1 Computer Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Helen Elizabeth Madison Robert Jene Lanphear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ${\tt IL60515}$ 19a. Informant's Name/Relationship (Type, Print) 3737 N. Highland Avenue Apt. 108 DownersGrove Wright /Sister Roberta other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or otl cemetery, crematory or other place 05 ☐ Burial 2 Cremation 3 ☐ Removal from State Jan Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Chesapeake Crematory M01443 22. Name and Address of Facility Funeral Alternatives Signature of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Demenlia Physician/ 1 cmous Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 SB IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) after death.

Director; After this certific
I in by the funeral director, Be examiner? Other: 2 **Y** No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft To the Funeral Dis completed filled in Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 34359 (01+10) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard, Baltimore, Maryland 900 Lock 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 201 Delores Mamiel Morgan 20:30M Trinuary Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood Battimore Future Care-If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Ye 1 □ M 2 🛛 F Months Days Hours MD Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-fs. other traumatic event, the Medical Examiner must be notified. Baltimore GWYNN Oak 1 Tes 2 No MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21207 3500 Tulsa Morgan , Delore 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Marylahd 21215-0036 1 ☐ Yes 2 No Specify: Specify: 15 ack 3 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Healthcare Elementary/Seconday (0-12) College (1-4 or 5+) LPN 12tharade 2 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 baxter Jones Ada V. Harris permit. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Tulsa Road Grynn Call, MD 21207 Mildred Wilson Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01.14.2011 Woodlawn, MD Noodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) C. Greene Funeral services 22. Name and Address of Facility Vaugnn 21. Signature of Funeral Service Licenses auch Road Randallstrum MD 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as profile or respiratory arrest shock, or hear failure. List only one cause on each line Approximate Interval Between Onset and Death immediate Cause (Final Pnysician/ unosclerotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying
Cause (Disease or linjury Date for Extraggle consequences of been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death 1 Yes 2 1 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting () the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VIE sumed masses 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerform death? Yes 2 No 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 📑 No 2 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature Date signed (Month, Day, Year) 0043378 2016 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) TAZTHOLE, MY 2178 35 MENNOTT STITA 28 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 6, 2011 11:00 а м Melva Bessie Mial Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 F Months Days Hours Min. May 1927 Maryrand 219-20-6612 83 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director **Baltimore** Timonium 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21093 12201 Burncourt Rd., # 203 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental h ည Estella Smi th C. Jacobs Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Cheryl L. M. Nickol-daughter 1712 Parsonage Rd., Parkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Parkville, MD 1/11/11 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lidensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Prumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by aticul 66n11 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 Yes 2 No this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After work?
1 Yes 2 No injury Natural 5 Pending Accident Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 20070 G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 1 (65 Char Pat 101

DHMH 17 Rev 7/2009

State Registrar

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1625 Medical 1am 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Bel Air 8. Date of Birth (Month, Day, March O 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ★ M 2 □ F Hours 220-42-9942 ቸ943 Mary land 67 Director Usual Residence of Decedent or 28a-f shov e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Maryland Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ems 23a or r must be r Funeral 21234 3301 Northway U.S.A. Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten ledical Examiner n Armed Forces Black, White, etc. Yes 2 No þ 1x Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Cosmetologists Barber Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen IreneCasev William Henry Meyers Page 1 and 2 should be nent of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Willrich Circle ForestHill, Maryland Winifred Jara / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State New CathedralCemetery 1/10/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fundame Lio 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to bras a consequence disease or condition Medical resulting in death) Examiner Sequentially list conditions, late cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consuluence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform Hospital or Attending Physician: The I 24 hours after death.
Funeral Director: After this certificate hated filled in by the funeral director, page Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 잍 1 ☐ Yes 2 😿 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de:

To the Funeral Director

completed filled in by th 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ca 66641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER CHESAPEAKE DR BEZ AIR LISA KIRKLAND 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	-	artment of Health and	Mental Hygier	ne	00101
		1	State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	rtificate of Death	Reg.	No.	10184
	Physicia	n/	Margaret Anne McCurry				7 2011 Year	3. Time of Death 2:39 a M
	Medic Examin		ta. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Dear	h	4c. County of Death	
لمرر			2309 Kezey Court		Crofton		Anne Aruno	
	Funeral Director		5. Social Security Number 212-66-7962 6. Sex 1 ☐ M 2 🕱 F	e (In yrs. last birthday) 56 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birth Cour	place (State or Foreign htry) Md .
	d t to w	_ h	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	larylar Sa-fsh ified	ecto	Md. Anne Arundel	Cro	fton			1 🗆 Yes 2 🛣 No
	the N a or 28	ä	10e. Street and Number		10f. Zip Code	1 "	Citizen of What Cou	ntry?
	h with	Funeral Director	2309 Kezey Court	To the local	21114		SA	
36	be filed within 72 hours after death with the Maryland antial tyygiene. Red other than "hatural", or items 23a or 28a-f show ked other than "hatural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent I Armed Forces? 1 ☐ Yes 2 M If Yes, Give Year or Dates.	No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ເNo Specify:	pecity Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Wh:	
9	hours natura lical E	olete	15. Decedent's Education		dent's Usual Occupation kind of work done during most of wo	ntking 16b	. Kind of Business Ir	ndustry
215	nin 72 ne. than "l e Mec	omo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 1)	5+) life. D	nistrative Assist		IRS	
2 2	ed with Hygien other i	Be C	12 Yrs. 17. Father's Name (First, Middle, Last)	Adill		ame (First, Middle, Maid		
an	ould be filed with nd Mental Hygier is marked other tumatic event, the	7	Thomas F. Dore			ne T. Roma		
Maryland 21215-0036	등 등 등 등		19a. Informant's Name/Relationship (Type, Print) John Robert McCurry (Husban		ng Address (Street and Number or A Kezey Ct. Crofto			Code)
ē,	of Health of Health fitem 27 rother tra		20a. Method of Disposition	20b. Place of Dispo			. Location - City or T	own, State
<u>E</u>	Page 1 ment of ant: If it ury or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Lake View	w Mem. Gardens 01			
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Fundervice Licensee	22	2. Name and Address of Facility Ha P.O. Box 195 Syke	aight Funer esville,Md.	al Home & 21784.	Chape1
П			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	d the death. Do not ent e.	ter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	blastoma	: multiforme			Onset and Death
mode	Examiner		Due to (or as	a consequence of):			1	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence oij.				
	cuted and transit	Examiner	that initiated events	a consequence of):				
	be exe	dical E	resulting in death) Last Due to (or as	a consequence on.				
760	cate l	fedio	d					
89 x	ath certif attending for use a	Physician/Me	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli-	very Day Year
B	he des y the s iched f	hysic	1 Yes 2 PNo 4 Pregnant 9 Unknown 9 Unknown	at time of death 3 t	- Other (openity)			
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ed by P	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.		co use contribute to	the cause of death?
cord	law requals been as been electrical been elect	Completed by				24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
Re	r: The ficate I	Cor	25. Was case referred to medical		26. Place of Death (Ch	1 🗆 Yes 2 🗷		2 - No
Vita	ysicial s certi directo	To Be	examiner?	tient 2 ER/Outpatie	Tou	Home 5 Residence	e 6 🗆 Other (Specia	5y)
J of	ding Phy The After this funeral of		27. Manner of Death 1 Natural 5 Pending 28a. Date of inj (Month, Date of inj	ury 28b. Time o		28d. Describe how in		
ivisio	or Attendation of Attendation of Attendation of Sirectors in by the	Certificate:		jury - At home, farm, st tc. (Specify)		28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
Δ	lospital t hours a uneral E ed filled	Medical (29a. Certifier 1 ☐ Certifying Physician: To the best of (Check 2 ☐ Medical Examiner: On the basis of	examination and/or inve	stigation, in my opinion, death occurre	d at the time, date and p	lace, and due to the c	ause(s) and manner stated.
	thin 2, the Formula 1, the Formplet	Me	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	e best of my knowledge,	death occurred at the time, date and a 29c. License number	place, and due to the cau	se(s) and manner as s	stated.
	F 3 F 8		Peter And a	10	D56977		1/7/20	-
	•		30. Name and address of person who completed cause of Peter Su M.D. 1438 Defense		Print)		54.	
	Sta	te	31 Date filed (Month Day Year) 32 Pegist			10,110, 210.	7.	
	Registr	ar	JAN 1 0 2011	un B. A	backer			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 20° ar 220A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice at Northwest Hospital Baltimore Randallstown 6. Sex If Under 1 Year If Under 24 Hrs. 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 👿 F Months August 4. South Carolina ⁴978 **Director** 229-28-2283 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☑ Yes 2 ☐ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4319 Kennison Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or ģ 1 Mever Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatin event, the Medical! 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Presser Laundry 6th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Manning Walter McFarland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Springdale Avenue Baltimore, Maryland 21216 Louise Parker - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial Park 1/11/2011 Arbutus, Maryland 21. Signatur of Funeral Service L censes 22. Name and Address of Facility
Chatman Harris Funeral Home
5240 Reisterstown Road Baltimore, Maryland 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line.

Indicate Cause (Final disease or condition) Approximate Interval Between Onset and Death MesoTheLions Physician MALIANAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that Initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death
Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy nerform death? certificate | Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or inventigation in a more death of the cause of examination and/or inventigation in a more death of the cause of examination and/or inventigation in a more death of the cause of examination and/or inventigation in the cause of examination and/or inventigation in the cause of examination and or inventigation 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) MP

Registrar

DHMH 17 Rev 7/2009

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0720 AM 04 2011 anuary /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death **Examiner** 05 Baltimore 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 ☐ M 2 🖫 F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MDimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ò 21216 23a onawood Funeral or items 2. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Blac \$ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) osme Hame (First, Middle, Last) Be lear toreman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. 2103 21216 pyombuo 20b. Place of Disposition (Name of cemetery, crematory or other place, c. Location - City or 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final oronan **Physician** O year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an certificate has Vital 1 □Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Attending 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No lospital or Attendl hours after death. uneral Director: A death. 2 Accident investigation filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 04, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Ave, Balhmore, MD 21229

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 2011 MINTER 12:26 A M DAVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country)

Ct Virginia Days (Month, Day, 1 Hours Min. 87 **Director** 232-<u>24-8114</u> West Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD HARFORD **ABINGDON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 1106 WALNUT HILL CT 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced BLACK Year or Dates. unknown 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4th WELDER STEEL INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MINTER LAURA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICAH U. MINTER/SON 1106 WALNUT HILL CT. ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗆 XCremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 1-7-2011 Baltimore, MD 22. Name and Address of Facility
William C. Brown Community Funeral Home-Harford P.A 21. Signature of Fureral Service Ligensee Mu Philadelphia Blvd. Aberdeen. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ and sta disease or condition resulting in death) Due to (or as a consequen of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in july that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Director: A Accident
Suicide Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Davids A32271 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 DAVID

31. Date filed (Month,

DUNN

JAN 0

615 W

BEL AIR

21014

MACPHAIL ROAD

32. 96gistrar's Signature

Registrar
DHMH 17 Rev 7/2009

State

OSLER DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D.

7601

LOW

TIMOTHY

D24034

TOWSON, MARYLAND

Through the control of the control o	1-00071 Timothy McCoy	Si	pe or Print in Blac ate of Maryland / [Department o	of Health and			egible.	
Trinchly Ray McCoy ### Children County ### Charge State of County ### Children County ###			20.0	Certificate of	of Death				11 00189
Control Cont	Physician/ Medical Examiner	Timothy Ra	у МсСоу				Month January	Day Year 2, 2011	1341 hrs
214 - 0.8 - 71.89		,				Location of Death			
Second Control Contr		1	6. Sex 7. Age (I	In yrs. last birthday)					
Baltimore Rosedale Rose			1 X M 2 F	43 Y		Hours Min	Marc	h17,196	Country)MD
The state of the s	.	MD Balt		•	dale				1 Yes 2 No
Secretary Secr	he Mary 1 or 28a- iffied at		m Avenue			7			at Country?
Secretary Secr	eath with t		arried Armed Forces?	If					
Part Company	ral", or		orced If Yes, Give Year or Dates:	1					
Part Company	2 hours "natus			during				16b. Kind of Bus	siness/Industry
Part Company	036 vithin 7 ene. er than Medica			Mill					
Part Company	e filed tal Hygint tal Hygint the other of t		•						
Part Company	hould bend Men is marl					t and Number or F	Rural Route N	umber, City or Towr	
Part Company	e, MI and 2 s fealth a item 27 traum	20a. Method of Disposition	- · · · · · · · · · · · · · · · · · · ·	20b. Place of Dispo	osition (Name of cen	netery,	Date	20c. Location -	
Part Company	MOFO			Holly	illi Ceme	etery 1	/8/11	Baltin	more MD
Part Company	Balti permit. Departn Imports Injury o	21. Signaturi di Juneral Service	Licansee /	14		30			
The following of the past of the cause of the cause of death? Comparison of the past of the past of the past of the past of the cause of death?	Physician	23a. Part I. Enter the disease, or	complications that caused he	e death. Do not enter	the mode of dying,	Lly Fun such as cardiac o	eral r respiratory a	Home of rest, shock, or hea	rt Approximate Interval
Sequentially list conditions, lifely livering, but immadists cause first Underlying Cause (Constituted to the cause of lifely livering to death Last Cause first Underlying Cause (Constituted to the cause of lifely livering to death Last Cause first Underlying Cause (Constituted to the cause of lifely livering to death Last Cause first Underlying Cause (Constituted to the cause of death?) Sequentially list conditions, lifely livering Cause (Constituted to the cause of lifely livery lifely lif		Immediate Cause (Final disease	a. Compli	cated by A	Asthma	ascular	Diseas	e	
WINDED 23a, pt.11, 27 per me g913 3-1-11 vt Second S		Sequentially list conditions,	b	1					
WINDED 23a, pt.11, 27 per me g913 3-1-11 vt Second S	mine	cause. Enter Underlying Cause		sence of):					
Security Cocaine Use Amenote 23a,pt.11,27 per me g913 3-1-11 vt The past 12 months? 23b. Was decedent pregnant in the past 12 months? 1	nted nd ransit			ience of);					
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	be exection and annual - tr	X UNPENDED	AMENDED 23a	,pt.II,27	per me g	g913 3-1-	-11 vt		
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	x 6876(h certificate tending physuse as the b use as the b ician/Me	23b. Was decedent pregnant in the past 12 months?	ne 1 Live birth 4 Pregnant at tim	2 F		Ectopic pregna	incy		·
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	b. Bo the deal		9 Olikilowii	ut not resulting in the	underlying cause o	iven in Part I	23e. Did	tobacco use contrib	oute to the cause of death?
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	s, P.C uires that n signed b id be deta	45.00-1.03	Solid Bulling to South Bulling	at not recording in the	- and anying cause gi		1 🗌 Y	es 2 No 3	Probably 4 🗸 Unknown
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	Record The law requate has bee age 2 shou						aut	opsy proformed? de	nor to completion of cause of eath?
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	ician: Secrific rector, p		(Hospital: ==	2 ED/2 4		Othor ==			lau a
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	of V ng Phys After this nneral di	27. Manner of Death	1 Inpatient						
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	Sion Attendii death. ctor: /		ding stigation						
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	Division of American Division of American Director of American Director of American Observation of Ame	dete	id not be	y - At home, farm, str	eet, factory, office bu	uilding, etc.			r or Rural Route Number, City
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32, segistrar's Signature	he Hosp in 24 hosp he Fune pletely fi	(Check only							
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Manth, Day Year) 32. Segistrar's Signature	To II com		and manner stated.				a trio timo, da		
Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Manth, Certification) 32, segistrar's Signature		D_M)L	-		O.C.N	M.E.		January 3, 2	2011
State 31. Date filed (Manth, Days'(ear) 32. Registrar's Signature	9		· ·	,	0 W. Baltimore	Street, Baltin	nore, MD 2	1223	
	State Registrar	31. Date filed (Manth, Days) (925)		Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ladimir Mlodinov Physician/ Month 2:15 PM 2011 JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 BELARUS 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days 1272771926 Hours Min. 213-41-5797 84 **Director** Usual Residence of Decedent show r 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No BALTIMORE MD OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 241 OWINGS GATE COURT, #203 21117 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify "natural", Specify. Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 ELECTRICAL ENGINEER GOVERNMENT Be 17. Father's Name (First, Middle, Last) age 1 and 2 should be filedent of Health and Mental Hint; If item 27 is marked outly or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) 2 GREGORY MLODINOV IDA GELIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAYYA MLODINOVA/WIFE OWINGS GATE COURT, #203, OWINGS MILLS, MD 21117 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important; If any injury or BALTIMORE HEBREW CEM: 01/07/2011 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD . Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scatt MI. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Cancer Onset and Death Immediate Cause (Final Physician/ Metastatic Lung disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy this certificate 1 Yes 2 No Yes nin 24 hours after death.

the Funeral Director: After this certific inpleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Jother (Specify) Hospital 1 ☐ Yes 2 ☑ No Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DOUS+465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AV. 5-203, Balfimore, MD. 21209 N-S. Ruapakse, M.D.

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 15 per fh g925 3-27-12 yt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day MacIver Kara Lyn 2011 9:02 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital 01nev Montgomery Birthplace (State or Foreign Country) Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Date of bill... (Month, Day, Ye **Funeral** 1 M 2 X Months Days Hours **Director** 218-17-4903 Nov. Pennsylvania Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Germantown 0 10e. Street and Numbe 10f. Zip Code 10a Citizen of What Country? 23a Funeral 12912 Churchhill Ridge Circle 20874 United States items within 72 hours after death 12, Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Examiner Black, White, etc. "natural", or ģ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 ★No White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 4 Paralegal Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Walter MacIver Elizabeth Jean Tumolo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Llangollen Blvd. New Castle, DE 19720 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr. once. <u>Elizabeth Valentine</u> (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Date 5. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2011 Signature of Furieral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00981 933 Gist Silver Spring, MD 20910 Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Physician/ disease or condition e psis Medical resulting in death) Due to (or as a consequence of): Examiner Menmonia Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) month The law requires that the death certificate be executed End stree Liv
Due to (or as a consequence of): disease LIVER use as the burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Dav Year 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy perform After this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 068658 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kinnaul 18101 Prince Philip Dr. Olney, MD Gena Harpitel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 7 2011 Registrar Carka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 2, 2011 Physician/ Month Kathleen Beatrice Nichols 7:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Dove Hospice House** Westminster **Carroll County** If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 D F 219-32-1326 89 Director Yrs England May 18, 1921 Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director MD Frederick Mount Airy 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4101 Old National Pike 21771 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Vivan Brown Beatrice Burrows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Margaret Ostrowski Daughter 10680 Hilingdon Rd. Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State . Page 1 5 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury o Atlantic Crematory, LLC Jan 04, 2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Sater the claese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 month 1 Yes 2 XNo 9 Unknown Por Month Year Pregnant at time of death 5 Other (specify) Dav detached the P.O. ģ s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 N this certificate 1 🗌 Yes 2 🗎 No of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Shorther} \) Other (Specify) \(\text{Dave Hause} \) 1 Yes 2 🗆 🗡 🗘 ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft. (Month, Day, Year) 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[In the place of the 29a. Certifier on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Praction of: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person of death (Item (3a) (Type, Print) 21157 MID 32. Registrar's Salature

Registrar DHMH 17 Rev 7/2009

State

DHMH 17 Rev 7/2009

State Registrar

			Please 1	Type or Print in	Black Ir	idelible Inl	k. Ensur	e All Copies	s Are Legible.	1 1196
		1	For State Registrar	State of Marylar	id / Depa <i>Cer</i>	tificate of	Death		Reg. No.	
	Physicia	ın	Doris		Pa	tterson		2. Date of De Month Januar	-y 05 2011	2:50 A M
1	/Medic Examin	er '	la. Facility Name (If not institution, give si			4b. City, Town, o		Death	4c. County of Dea	ath
	Funeral		The Johns Hopkins Hos		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Min. 8. Date of Bit (Month, Di		irthplace (State or Foreign ountry) MD
	Director ≥	-	218 - 38 - 3477 July 10a. State 10b. County	/ 1	ity, Town or Lo	ocation		104 12		10d. Inside City Limits
	e Maryla 8a-f sho tified at		MD NA		Balti	more			10g. Citizen of What C	1 🕅 Yes 2 🗆 No
	th with th	Funeral Director	723 N. Carey			212			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	 12. Was Decedent Ever in UArmed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No		n? (Specify Yes or No Puerto Rican, etc.)	Black, Wh	nerican
215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give	edent's Usual Occi e kind of work don DO NOT use retire	e during most o	of working	Homemak	
nd 21	be filed wil tal Hygien d other thi svent, the	Be Con	8th Grade 17. Father's Name (First, Middle, Last)	NA unk.	DC	omestic		's Name (First, Middle	Tromemak e, Maiden Surname Hall	<u>er</u>
Maryland	2 should I and Meni is marker	욘	19a. Informant's Name/Relationship (Ty) Ellen Williams				et and Number	or Rural Route Num	ber, City or Town, State	
nore, I	ages 1 and nt of Health: If item 27		20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b	Place of Disp cemetery, cre	position (Name of ematory or other pi	lace)	Date 11-13-11	20c. Location - City Lansdow	or Town, State
Baltimore,	permit. Poppartme Important any injury once.		21. Signature of Funeral Service License			22. Name and Ado	Iress of Facility		uneral H Baltimor	ome P.A. e,MD 21217
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	le cause on each line.				cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. hy povo ler		ischer	MIC K	300001		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
,09	e be executed sician and be burial-transit	<u>a</u>	resulting in death) Last	Due to (or as a consi	equence of):					
. Box 6876	death certificate be te attending physicia ed for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 F 4 Pregnant at time o	etal death 3	B ☐ Ectopic pregna □ Other (specify)			23d. Date of Month	delivery Day Year
ls, P.O	v requires that the de been signed by the a should be detached	by	Part II. Other significant conditions co	entributing to death but not	resulting in the	e underlying cause	given in Part		d tobacco use contribu Yes 2 No 3	te to the cause of death? Probably 4 Unknown
Division of Vital Records,	e lav has l ge 2	Completed						24a. Wa au pe 1 D Yes	topsy prior rformed? deat	
/ital		Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	□ □□ □□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	ient 3 🗆 DOA	Othori	of Death (Check only		Specify)
n of	Attending Physician: or death. ector: After this certifice by the funeral director,	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur	e of 28c. It	njury at Vork?	28d. Describ	pe how injury occurred	
Divisio	or Attendia after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, cify)			28f. Locatio	n (Street and Number of Town, State)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Ph (check only one) 2 Medical Exam	ysician: To the best of my land manner stated.	nowledge, de ination and/or	ath occurred at the investigation, in n	e time, date an ny opinion, dea	nd place, and due to ath occurred at the til	the cause(s) and mann me, date and place, and	er as stated. If due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	1 /whe			ense number	n	29d. Date signed (N	onth, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chillstand Grant Cocke

31. Date filed Morth, Pay Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AM M 01 2011 5:47 <u>Arthur E. Price</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1807 Angleside Road Social Security Number 6. Sex Harford Fallston 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours. (Month, Day, Year) 03/17/1928 Country)
Marvland Director 82 216-20-1569 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Fallston 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1807 Angleside Road 21047 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Korean Conflict If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 12 Motor Fuel Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blanche Louise Urie James Elsworth Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 472 Woodlands Hill Lane - Oakland, Maryland (daughter) Karen A. Price 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/04/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mage disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature son who completed cause of death (Item 23a) (Type, Print) Name and address of

DHMH 17 Rev 7/2009

State

Registrar

0

arke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 0930 M Peacock, III. January Samuel Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6306 Moyer Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Davs Hours Min. 05-18-1925 85 213-20-2426 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A 1 X Yes 2 No Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6306 Mover Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married Yes Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White WII Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Private Engineer Company Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Marion Peacock, Jr. Rose Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Esther M. Peacock - Wife 6306 Moyer Avenue Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Parkwood Cemetery 01-11-2011 Baltimore, Maryland 21. Signatur of Soveral Service Lice 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck. Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOM Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) 6 months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated expense. Examine bue to (or as a consequence or) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year Other (specify) been signed by the should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. ò wn Completed certificate has be irector, page 2 s director, Be ၉ Certificate:

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this thin 24 hours after death.

the Funeral Director: At mpleted filled in by the fu

		1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknow
		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check	
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 KResidence 6 🗆 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how injury occurred
3 Suicide 6 Could not b	28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,

🛕 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Day, Year)

MD

21239

City or Town, State)

LOLH RAVEN BLVD.

State Registrar

Medical

31. Date filed (Month, Day, Year) Registrar's Signature

building, etc. (Specify)

within 2

To the F

complete

arke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene f - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:150 M Physician/ Jan Medical 4b. City, Town, objection of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 2708 Boker 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 98 Months Davs Hours Min (Month, Day Corner Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2708 12. Was Decedent Ever in JJ.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify. ac 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee, 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pproximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pa, ician/ disease or condition resulting in death) Medical Due to (or as a consquence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or imjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Dav Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown n signed by the a ld be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**/**No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performe After this certificate 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: **20**√2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1
Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗆 No Accident Investigation after death the Funeral Direc. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Portifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifing 29d. Date, signed (Month, Day, Year) 6/1

State Registrar

DHMH 17 Rev 7/2009

Registrar's Signature

2122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day James Norman Phillips January 06, 2011 10:40 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Carney Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. Hours 89 Months **XX**M 2□ F 215-18-7692 Baltimore, Maryland July 22, 1921 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Baltimore Maryland Carney 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21234 United States 8800 Walther Blvd Apt 1320 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1 XX es 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2XXMarried 2 No 1 ☐ Yes 2XXXVo Specify. White Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Phillips, Sloan, College (1-4or 5+) and Silverman Attorney/Partner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norman Phillips Florence Arnold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia L. Phillips (Spouse) 8800 Walther Blvd Apt 1320 Carney, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility

Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations to indiffed at

and I

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau

/Medical

Director

Funeral

þ

Completed

Be (

ျှ

loyoun

1/6/2011

Division of Vital

Hospital or Attending Physician: To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

	23a. Part1. Enter the disease or com shock, or heart failure. List only Immediate Cau e Final		, 0.	or respiratory arrest,	Approximate Interval Between Onset and Death			
	disease or condition resulting in death)	a Cere brovascula, Dise	OCK					
	resulting in death)	Due to (or as a consequence of):						
niner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury	bDue to (or as a consequence of):						
Exa	that initiated events resulting in death) Last	C Due to (or as a consequence of):						
Sica		d						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		dd. Date of delivery Month Day Year			
7	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
g p	Vascular Demen	tra, Hypertensive Cardio	vaxular	1 ∐ Yes 2	No 3 Probably 4 Unknown			
plet	Disease			24a. Was an	24b. Were autopsy findings available			
E CO				autopsy performed2 1 ☐ Yes	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
e Re	25. Was case referred to medical examiner?		26. Place of Death	n (Check only one)				
0	1 Yes 2 No	Hospital: 1	DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)			
ertification:	27. Manner of Death ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	28c. Injury at Work?	28d. Describe how injur	ry occurred			
ertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)			
3								
edical Ce		ysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated.						

Registrar

CKM MSN 8800 Walther Blud, Parkville MD 21234

CRAP MX

Registrar's Signature

30. Name and address of person who commeted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0700 AM Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** N/A 8. Date of Birth (Month, Day, 9 / 2 / 5 2 Security Numb 6. Sex Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🔀 F 58 215-60-5579 Director MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director N/A MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 38 S. Carrollton Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Completed by African Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 3 - Widowed 4 - Divorced Amer 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Medical Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment. Important: If item 27 is marked any injury or other transporce. ပ James Allen Jones Elizabeth Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony James Smith, Sr. S. Carrollton Ave, Balt., MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garrison Forest 1 XBurial 2 Cremation 3 Removal from State 1/14/11 Dwings Mills,MD VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA Signature of Funeral Service Licenses 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury to (or as a consequence of) requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician as the burial-t Completed by Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes the Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 X Yes 2 🗆 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending n 24 hours after death.

e Funeral Director: Affeted filled in by the fur 2 🗌 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотріете 3 🖟 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JANUARY earson 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER BULNIE CLEN ARUNDEL ANNE 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 X M 2 🗆 62 0670271948 218-44-2652 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Anne Arundel Severn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1527 Wampanoag Drive 21144 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Completed by 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Pierson Mollie Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1527 Wampanoag Drive Severn, Md. 21144. Shirley Pearson (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Md. cemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) Sharon Baptist 01/08/2011 West Friendship 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis, Peripheral Vascular Disease 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No ပ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

31. Date filed (Month, Day, Year) JAN

29b. Signatun

Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 11:18\$ M aiker Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Baltimore Washington Medical Center Glen Burnie Arunde1 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) 1 ☐ M 2 🗓 F Months Days Hours **Director** 219-30-5975 07/10/1933 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2X No Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 1029 Glenvilla Drive 21061 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3X Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper GC Murphy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Joseph Ringrose Evelyn Catherine Dunkerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kimberly Harris /Daughter 815 Lucky Road Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 01/10/2011 Baltimore, MD 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nultisyktem Physician/ disease or condition Medical resulting in death) Due to (or as sequence of): **Examiner** acute Vehydratim Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Dav Year Pregnant at time of death g Unknown g 🗌 Unknown signed by to Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by partensive Heart 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' After this certificate I funeral director, page ☐ Yes 2 🗷 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Yes 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA မ 24 hours after death.

Funeral Director: After this ested filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 45148 6,2011 UCTOR WYUUTY ess of person who completed cause of death (Item 23a) (Type, Print) , SWIPA Muuntan Kood State Registrar

11-00130 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Patrick Pena State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1226 hrs Medical Examiner January 4, 2011 Michael Patrick Pena 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 12893 Eagles View Road **Baltimore County** Phoenix 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex **Funeral** oreign Hours Director 1 XM 2 F CountMaryland 34 Yrs <u>213-23-2404</u> Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Md. Baltimore Phoenix Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12893 Eagles View Road 21131 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 No specify: Specify: White ğ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) +2 Landscaping Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mary Ann Wilson Alberto Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberto D. Pena/ Father 4611 Piney Grove Rd. Reisterstown, Md. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1-10-11 Timonium, Md. Dulaney Valley Mem. 4 Donation 5 Other Specify 22. Name and Address of Facility
RUCK TOWSON Funeral Home, Inc. 21. Signature of Funeral Se 1050 York Rd. Towson, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last e attending physician and for use as the burial - transit Physician/Medical AMENDED 23a,27,28a-f per me g912 2-2-11 vt X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed by funeral director, page 2 should be detach 歹 Completed 24a Was an autopsy performed death? Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA 1 Yes 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Natural 1 Yes 2 No Pending fd 1-4-11 fd 11:59am unknown Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide (Specify) house Homicide

20c. Location - City or Town, State Approximate Interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Certification filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12893 Eagles View Rd. Phoenix, Md. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME January 5, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State arker Registrar OCME DHMH 17 Rev 1/2001 **ORIGINAL OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Ray 11:21 AM ANHARY OG. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 □ F Months Days Hours Min 9/22/1917 93 Mary land 215-05-9508 Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City. Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director Mary land Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 305 E. Joppa Road Apt 201 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Machinist 2 should be filed within 72... th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing the 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Dorsch Harry Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 305 E. Joppa Road Baltimore, Maryland 21286 Tony Guarino / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/11/2011 Druid Ridge Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TRACT Pnysician/ URINARY disease or condition resulting in death) Medical Examiner Sequentially list conditions, dram, leading to immedia cause. Enter Underlying Cause (Disease or linjury Examir requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATH 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an has 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending nours after death.

neral Director: Af
I filled in by the fur M Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certi 29d. Date signed (Month. Day, Year) D0069989 1.6.11

DHMH 17 Rev 7/2009

State

Registrar

THOI OSLER DRIVE TOWSON MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

ALEXE' MALININ

10 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 ear January 10:30 AM Harry Frederick Ruggiero Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Timonium . Social Security Numbe If Under 1 Year If Under 24 Hrs . Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Country) Maryland 01/22-1918ar 217-05-6873 9 **Director** Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō A.M. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral Straffan Drive 21093 IISA Unit 103 620 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced WII White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore Dept. of College (1-4 or 5+) permit. Page 1 and 2 should be filed within ' Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the M Elementary/Seconday (0-12) Mason Education Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Tartaglia Vito Ruggiero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Straffan Drive Unit 103 Timonium, MD 21093 Mrs. Janet Harsher - Niece Baltimore, ANUARY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗐 Removal from State Most Holv Redeemer Cem. 01-12-2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature / Fin ral Service L/ ny e 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 4 ☐ Pregnam 6 9 ☐ Unknown been signed by the s should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 600 40 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law **Director:** After this certificate has in by the funeral director, page 2 s autopsy perforn death? RUGGIERO, HARRY 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA Hursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 ☐ Yes 2 ☐ No Natural after death. Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifier 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 DULANEY VALLEY ROAD 21093 TIMONIUM MD31. Date filed (Month, Day, Year) State Jacker Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #1 Per Phy G911 1/26/2011 Jh State of Maryland / Department of Health and Mental Hygiene 00205 State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Jason Philip Roth January 5. JASON PHILLIP ROTH 4:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson Baltimore 5. Social Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 03/09/1954^{Year)} 1 X M 2 - F 217-64-2587 Maryland 56 Yrs. **Director** Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7312 Yorktowne Drive 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked off any injury or other traumatic even once. ပ္ Raymond Levi Roth Neva Irene Holtzapple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neva Irene Roth Mother 7312 Yorktowne Drive Towson Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 01/10/2011 Timonium, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Sol 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc vjce Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the discrete, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ une cancer disease or condition resulting in death) Medical Due to (or as a co) sequence of): Examiner Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Yunknown tor: After this certificate has been si the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 WNo Other: ပ Hospico 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature, and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultmore MD ZIZOY St Pate1 charles laura 61 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 0 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Ruth Rhodes Jan 1, 2011 10:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mt. Airy Carroll Lorien Nursing Home of Mt. Airy Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8 Date of Birth Funeral Days Min (Month, Day, Year) Nov 29, 1924 1 DM 2 X 067-24-24-4540 86 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **Baltimore** Catonsville 1 🗆 Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane HR 434 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac Garrit Roorda Anna Terlouw Roorda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Rhodes 407 Bridlewreath Way Mount Airy, MD 21771 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Atlantic Crematory, LLC Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 ure of Funeral Project Licenses 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ on ascinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter throughing Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hours and action and the strange of the attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 L Ferance.

Pregnant at time of death Ectopic pregnancy in the past 12 months? Month ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 4 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2011 DO059423 mo Or 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ndidi Feinberg Stratfie W 1St Floor 11165 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00207 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Yvonne Roach Month Year 0733 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico <u>Peninsula Regional Medical Center</u> alisb If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 212-34-0508 1 M 2 X F Months Days Hours Min July 26. 1937 73 Mary Land Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f showther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Owings Mills Maryland Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 4620 Deer Park Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Operator 1 contracts Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Luther William Roach Hattie Lee Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Sollers 1316 Holt Ct., Eldersburg, Maryland (Niece) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t 20b. Place of Disposition (Name of crematory crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory, Inc. 1/7/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral prvice Licensee Revin E Foker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SHOCK TIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner INGETTION MRY TRACT Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3

Ectopic pregnancy **To the Funeral Director.** After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for r Month 5 Other (specify) Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNo Hospital Other: မ 1 Yes 1XInpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number MD DOOT127-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed MD Suite 104B SAlisbury me 106 Milford St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dennis Roy Reilly	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	00208
Physician Medical Examine	Damaia D. Davilla	3. Time of Death 2231 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 507 Nollmeyer Road 4c. County of Death Middle River Baltimore County	
Funeral Director	1657	
bo wany	MD Baltimore Middle River	10d. Inside City Limits 1 Yes 2 No
ath with the Maryland tens 23s or 23s-f sho at be notified at once the maral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count USA	try?
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once 18a by Furneral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: Specify: Whi	
2 3 -	Specify: W111	
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natt c event, the Medical Exa		
re, MD 212' Land 2 should be Health and Menta friem 27 is marke or traumatic even To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 Jessie M. Reilly /wife 507 Nollmeyer Road Balto. MD 212	Zip Code)
Baltimore, permit. Pages 1 an Department of Hea Important: If iter	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donatieq 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILL Cemetery 1/10/1 Baltimo	•
Physician Physician	21. Signature Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Bal Connelly Funeral Home of Esse 23a. Part I. Enter the disease, or convellcations that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart	
/Medical Examiner	failure. List only one cause on each line. Mixed Drug (Amitriptyline and Bupropion) and Immediate Cause (Final disease or condition resulting in death) Mixed Drug (Amitriptyline and Bupropion) and Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Between Onset and Death
led Insit Examiner	Sequentially list conditions, If any, leading to in mediate Cause. Enter Underlying Cause (Disease or injury that initiated C.	
50, te be executed ysician and burial - transit	events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED AMENDED 23a,27,28a-f per me g913 3-1-11 vt	
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical E)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown 23d. Date of delivery Month Da	y Year
ls, P.O. Equires that the can signed by the lide be detached lead by Physical	1 Yes 2 No. 3 Probal	bly 4 Unknown
tal Records, cian: The law require: certificate has been sigector, page 2 should be Be Completed		psy findings available inpletion of cause of
Ing Physi ling Physi After this funeral dir	1 Ves 2 No Pote of Injury 29b Time of Injury 29b Injury 20b Injury	edications
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		
To the within 2 To the complete	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) January 4, 2011	
	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	OCARE	
DHMH 17 Rev 1/2001	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY NINAROSENTHAL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAGERSTOWN WASHINGTON LOYALTON NURSING HOME Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min Country) 0371471922 88 **Director** 220-24-6115 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland ural", or items 23a or 28a-f sho I Examiner must be notified at Director 1 Yes 2 V No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 POMONA EAST, APT. 310 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates "natural", Completed 3 XWidowed 4 Divorced WHITE traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME Be permit. Page 1 and 2 should be flec Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 VICTOR JENNIE KOLKER EHRLICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETSY ROSENTHAL/DAUGHTER 13523 EDGEMONT ROAD, SMITHSBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CEMETERY 01/06/2011 BALTIMORE, MD

Physician Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran

After this

24 hours after deatl Funeral Director:

within 2 To the F

by Physician/Medical

Completed

Be 은

Certificate:

Medical

IF FEMALE:

Baltimore, Maryland 21215-0036

Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

21. Sphature of Funeral Service Licen

23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications to	hat caused the death. Do not en on each line.
Immediate Cause (Final disease or condition resulting in death)	a. Du	e to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Du	e to (or as a consequence of):
Cause (Disease or injury that initiated events resulting in death) Last	c. — Du	e to (or as a consequence of):

8900 REISTERSTOWN ROAD, PIKESVILLE, ter the mode of dying, such as cardiac or respiratory arrest

22. Name and Address of Facility SOL LEVINSON & BROS. INC.

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								

23e. Did tobacco use contribute to the cause of death? 2 ₽ No 3 Probably 4 Unknown autopsy findings available o completion of cause of es 2 No

23d. Date of delivery

Dav

21208

Year

Approximate Interval Between Onset and Death

		24a. Was an autopsy performed? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 1 \(\sum \text{Yes} \) Yes
25. Was case referred to medical	26. Place of Death (Check of	only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?	3d. Describe how injury occurred

		1 🗀 Inpatient 2 🗀	EH/Outpatient 3 L	J DOA L	Nursing F	Home 5 - Residence 6 - Other (Specify)
7. Manner of Death		28a. Date of injury	28b. Time of	28c. Injury at		28d. Describe how injury occurred
1 Natural 2 Accident	5 Pending Investigation	(Month, Day, Year)	injury M	work? 1 🗆 Yes	2 🗆 No	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he		ctory, office		28f. Location (Street and Number or Rural Route Number

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sta
only one)	3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier	29c. License number	29d. Date signed (Mpnth, Day, Year)					
In Sum P Beck mn	D16941	1/5/11					

 Name and address of persor 	n who completed cau	ise of death (Item 23a) (Type, Print)				
Samuel	Benish	2700 QUANTY	Lyla Dr Suile	350	B411. md	21200
Date filed (Month, Day, Year)	20 1	Pagintrar's Cianatur				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 201 Month 10:35 PM January 2, Frances Adelaide Roth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Dulanev Vallev Lutherville-Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours May 13, 1929 81 Director 214-24-4754 Country) Maryland Usual Residence of Decedent or items 23a or 28a-f shov 10a. State 10b. County with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No Essex 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 1800 Beechwood Avenue 21221 United States death 1 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2. No Specify: "natural", Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene 12 Home Maker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) **John**Humphreys 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marie Bushman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Lawrence /Daughter 170 Branchwood Ct. Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Jan 06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Stanislaus Cemetery 2011 140144 Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ PANCREATIC CANCER) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months?

1 Yes 2 No Day Year page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peen s 24a. Was an 24b. Were autopsy findings available 24 hours after death. Funeral Director: After this certificate has prior to completion of cause of death? autopsy autopsy performed? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury work? 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the P only one) 29b. Signature and title 29d. Date signed (Month. Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES. CRNP 2300 DULANEY VALLEY RD. Year) MD 21093 TIMONIUM. 31. Date filed (Month, State Registrar's Signatur

DHMH 17 Rev 7/2009

Registrar

h

JANUARY

				Plea	ase Type or P						•		_		
		•	1 - For State of Maryland / Department of Health and Ment Certificate of Death									giene Reg. No	2011	00211	
	Physicia Medio		1. Decedent's Name (First, Middle, Last) EUGENE RICKETTS								2. Date of De Month Januar		, 201 ^{Year}	3. Time of Death 6:00 p. M	
	Examin		4a. Facility Name (if Washingt		Location of Death		County of Death								
-5	Funeral Director		5. Social Security N 214-48-9	umber		Age (In yrs. Ia	ast birthday) Yrs.	If Under 1	_		8. Date of Bir Mar • Z				
	/land f show ed at	tor	Usual Residence of 10a. State		y, Town or Lo						10d. Inside City Limits				
	re Mary or 28a-1 notifie	Direc	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code									10a. Ci	itizen of What Cou	1 🗌 Yes 2 🖺 No	
	n with the ris 23a connect be	Funeral Director	10110 New Hampshire Ave. Apt.204 20903 United								ted Stat	es			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once</u> .	by	1 Never Married 2 Married 1 Yes 2 No							ecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White Specify: Whi	, etc.		
15-0	The state of the s									16b. k	6b. Kind of Business Industry				
212	l within ygiene. her tha t, the l	O C O	Elementary/Seco		College (1-4 c	r 5+)	ı	sman					sonry		
Maryland	d be filed Mental Hy arked oth	To Be	17. Father's Name (•					18. Mother's Nar Margare			Surname)		
, Mar	nd 2 shoulesalth and m 27 is mer traum		19a. Informant's Na Della Pa	me/Relations yne	hip (Type, Print) (domestic	partne	19b. Mailir 2r) 14(ng Address (S 070 Ho	Street a			r, City oi Mary	r Town, State, Zip 1and 217	Code) '50 	
Baltimore,	Page 1 ar nent of He ant: If iter ıry or oth		20a. Method of Disp 1 Burial 2 4 Donation	X Cremation	3 ☐ Removal from Sta	مد ا دد	lace of Dispo emetery, cren esapeal	natory or oth ce Cre	ner plac emat	ory; 2	01 1	Bel		Maryland	
Balti	permit. Departr Imports any inji		21. Signature of Fu	Pal Service L	Licensee	M00982	2 9:	Name and Gis	Addres	_{ss of Facilit} (ap ve. Silv	p Funera er Spri	al &	Cremati Maryland	on Service 20910	
	nysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death										Interval Between		
L	Medical Examiner		resulting in death)		Du to (or a	s a consequ	ence of):				Q				
	usit asit	Examiner													
	oe executed ician and burial-transit														
68760	ficate be g physici as the bu	Nedic			0										
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death this certificate has been signed by the attending physici for the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but a funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	h 2 □ Feta tattime of d	Ideath 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					23d. Date of delivery Month Day Ye		
ls, P.O.			Part II. Other signif	icant condition	fung 0700	but not resu	ulting in the u	inderlying ca	ause giv	ven in Part I.				the cause of death?	
Records,	The law require: sate has been sig page 2 should b	Completed by			/ //						24a. Was autop perfo	osv	prior to c	opsy findings available ompletion of cause of	
talF	sician: The certificate rector, pag	Be	25. Was case referre examiner?		Hospital:	2			_	ace of Death (Che					
of Vital	Attending Physic death. ctor: After this control of the funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive funeral directive function	e: 10	1 ☐ Yes 2 E		1, Inp	njury	ER/Outpatier 28b. Time of		c. Injur	4 ∐ Nursing H y at	ome 5 Resid		Other (Specification)	(y)	
ono		ficate	1- Natural 5 Pending (Month, Day, Year) injury work? 1 Yes 2 No 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural City or Town, State)												
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the f										al Route Number,				
	e Hospi 24 hou e Funer leted fill	Medical	(Check 2	☐ Medical E	Physician: To the best Examiner: On the basis of Nurse Practioner: To t	f examination	and/or invest	tigation, in m	y opinio	on, death occurred	at the time, date a	and place	e, and due to the ca	ause(s) and manner stated.	
_	To the within To the comp	-	29b. Signature and	title of ceptifier	r A			29c.	License	e number		29d. Da	ate signed (Month,	Day, Year)	
, ,	[30. Name and addre	ess of person	who completed cause of	death (Item	23a) (Type, F	CHT	CH	ININ	(A, 11	1. 1	7600 C	Carroll Ave.	
	Star Registra	te	31. Date filed (Monti						-11		,		Takulla	iaik, rib.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month erma 12:30 DM Januar 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kingr 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Virginia 1 🗆 M 2 🔯 F Hours Min. Director -42-9798 West Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits 23a or 28a-f 1 Yes 2 X No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8617 Drumwood Road 21286 U.S.A. items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐X No Specify. "natural", 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Sales Clerk Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ည Arthur Malcolm Bertie Shockev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherman 8617 Drumwood Road Towson, Maryland David 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 1-8-2011 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemeterv Moorefield <u>Virginia</u> Signature of Function Service 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. MONDE 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. Ust only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year the detached Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown has been 24b. Were autopsy findings available prior to completion of cause of page 2 death? performed this certificate Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital: 2 400 Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wrive Elknidge Mars 22 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year ARIE SIMONSEN 5.50 P AN 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner AUGSBURG LUTHERAN HOME BALTIMORE COUNTY BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 723-14-6614 Feb. Director 84 7,1926 Marylánd Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Baltimore Director Baltimore County 1 ☐ YesX2Y ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7528 Kenlea Avenue 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian filed within 72 hours after 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X**No Baltimore, Maryland 21215-0036 10 1 ☐ Yes ¾ 🙀 No Specify: Specify: White ð 3 ☐ Widowed XX Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, I'm and Jones. 12 yrs. Secretary National Casket Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Hoffmann Pearl Slitzer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7528 Kenlea Avenue Baltimore, Md. 21236 Sharon L. Brundick (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 1-5-2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the asi IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 호 Year Day 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe o NSOR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending Natural death. 1 □Yes 2 □No 2 Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide TECRITIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

2835

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 285

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per th g911 1-28-11 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:05 AM Prome anuar 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** altima Elizabeth UVSIITE Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 00th 50ay 1924 220-14-1520 Months Days Hours Mar V Yand 86 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 3320 Benson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Inventory Controller Clothing Factory 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leslie Schwartz Ella Singleton 19a. Informant's Name/Relationship (Type, Print) (daughter) Linda M. Schwartz (wife) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Lavender Avenue Pakrville, MD 21234 Method of Disposition
1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Lakeview Memorial 1/6/2011 Sykesville, Maryland 4 Dorfation 5 Other (Specify) 21. Signal re of Funeral Service Licenses Gary L. Kaufman Funeral 7250 Washington Blvd., Home at MMP, Elkridge, MD Inc. 21075 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on earn Immediate Cause (Final d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 211 Secure disity flet possible at if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical 115 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 211567

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State	State of M	aryland /	•				lental Hy	giene	001	0001		
		_	Registrar Certificate of Death							Reg. No.				Ü	
	Physicia									2. Date of Death Month January 8 2011 3. Time of Death 12:35P					
	Medic Examin		George Richard Stonesifer January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death								1	2011 County of Dea			
	-Admin		14722 Myer Terrace Rockville							, , ,			omery		
	Funeral		5. Social Security Number	If Under 1 Year Months Day	r If Und	der 24 Hrs.	8. Date of Bir	th	g, Bi	thplace (State or Forei	ign				
	Director		212-38-2043 Usual Residence of Decedent	1 🔀 M 2 □ F	72	Yrs.	World Day	11001		Month, Da Dec • 9	79	38 Mã	ryland		
	and show at	ě	10a. State 10b. County	,	10c. City, Tov	vn or Loc	cation						10d. Inside City Limit	its	
	Maryla 18a-f	rect	MD Moi	ntgomery	Roc	kvil	le						1 🗆 Yes 2 🗶	No	
	the land a or 2	Ö	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What C	ountry?		
	th with	Funeral Director	14722 Myer				208					.S.A.			
	r deat or iter iner i		11. Marital Status1 ☐ Never Married 2 ☒ Mar	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Yes, specify Cu	Hispanic ban, Mexi	Origin? (Spec can, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit			
Maryland 21215-0036	safte ral", o Exam	d by	3 ☐ Widowed 4 ☐ Divorced	If Voc Give	[№] 1961–6	8 1	☐ Yes 2 🔀 N	lo Spec	cify:			Specify: W	nite		
Ö .	hours 'natur dical	Completed		ent's Education		a. Deced	ent's Usual Occ				16b. Ki	ind of Business			
2	nin 72 Je. Han * e Mei	mo	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)								_				
2	d with	Be C	12 17. Father's Name (First, Middle,	5+		Aero	space to						vernment	_	
au	be file	일	Jacob Russell	,			18. Mother's Name (First, Midd) Anna Ritter					э, Maiden Surname)			
ary	nould nd Me s mar umati		19a. Informant's Name/Relations		19	b. Mailin	a Address (Stree			er or Rural Route Number, City or Town, State, Zip Code)					
Σ	d 2 sk alth a 27 is ertra		Elizabeth A.	Stonesifer-v			22 Myer								
ore	of He of He if item roth		20a. Method of Disposition 1 Burial 2 Cremation	2 Damayal from Chata		of Dispos	sition (Name of natory or other p	lace)	D	ate	20c. Lc	ocation - City o	Town, State		
Ĕ.	Page ment tant: I		4 Donation 5 Other				y Crema		1/11/	2011	Syl	kesville	e, MD		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fine 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur Fyneral Service	Licensee ROYMA	1_		. Name and Add		пал	rtzler	Fune	ral Hom	e 76		
	,		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
P	nysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition												
)	Medical Examiner		resulting in death) Due to (or as a consequence of):										2 / 5022	_	
		er	Sequentially list conditions,	b. Due to fer es		200									
7	nsit	Examin	if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease of impury												
	n and al-trai	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):												
9	cate be executed physician and the burial-transit	edical	d												
2/89	ng ph	Med	IF FEMALE:	T											
Box 6	ttrend or use	by Physician/M	23b. Was decedent pregnant in the past 12 months?	in the past 12 months?								23d. Date of delivery Month Day Year			
м.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	4 Tregnant at time of death 3 Dother (specify)										
P.O.	ned by detai	y Pi	Part II. Other significant conditi	ons contributing to death b	ut not resulting	in the u	nderlying cause	given in Pa	art I.	23e. Did to	23e. Did tobacco use contribute to the				
S,	uld be									1 🗆	Yes 2	XINo 3□F	No 3 Probably 4 Unknown		
Ö	as bee 2 sho	plet								24a. Was			topsy findings available completion of cause of		
VEGUCAS A PROCOCAS Significant Plan A caddings Significant Plan A caddings On a plan of the pay a sport of the pay and the								perfo	performed? death? 1 Yes 2 No 1 Yes 2 No						
ta 🤅	cran: ertific ector,	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)												
∑	rnysi this c	: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 No Residence 6 Other (Specify)									sify)			
0	th. After funer	cate	1 X Natural 5 Pendi	Alamah Da	, Year)	injury	28c. Inj wc M 1 [ury aτ ork? □ Yes 2		28d. Describe h	now injury	occurred /			
OISI	Attended description of the by the	Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Place of Inju	ıry - At home, f	arm, stre							ral Route Number,		
Division of	ral or rs afte al Dir ed in														
2	to the rospital or Autentury Priystoars, the law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										ated.		
4	vithii To th comp	-	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)												
		heyl algered 254378 1/10/11													
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
	Stat	Cheryl Aylesworth MD 2730 University Blvd. #400 Wheaton, MD 20902 tate 31. Date filed (Month, Day, Year) 32. Register's Signature									902	_			
	Registra		JAN	10 2011	moure	A.	farke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Мопt 01 2011 Scheller 06 12:00 a^M Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill Hart Heritage Estates If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) _s Funeral Hours 1 M 2 X F 0971371925 85 Director 220-24-2954 PA Usual Residence of Decedent show ŧ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f sledical Examiner must be notified 1 Yes 2 X No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1915 Rock Spring Road 21050 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natur jury or other traumatic event, the Medical". 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 State Of Maryland Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Scheller, Sr. Ella Katherine Sell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 Donald Circle, Forest Hill, MD 21050 Margaret Norman, Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/07/2011 Towson, Maryland Hilltop Svc. Corp. 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. 22. Name and Address of Facility ad of Subnoxel 5305 Harford Road, Baltimore, MD 21214 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) MO Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death Yes 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No After this certificate has funeral director, page 2 autopsy 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 2 3 No မ pre 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director, Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUL AIR, MD 21014 ALFRAD SPANULS W. MAR Phail 15 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 5:30 A. Charles Clifton Stran, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A 3838 Roland Avenue #511 Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Couldary Land Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 215-22-9195 1 M 2 - F Months Days Hours 84 November 27. 1926 Director Usual Residence of Decedent 28a-f show 10b. Coun 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director N/a Baltimore Maryland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral items 23a 21211 USA 3838 Roland Avenue #511 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Armed Forces?

1 X Yes 2 N Black, White, etc 1 Never Married 2 Married and Mental Hygiene.
is marked other than "natural", or þ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give Year or Dates. WII 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Klicos Company Painter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Anna Marie Baker Morton Dudley Stran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3838 Roland Avenue Baltimore MD 21211 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Shirley Kathryn Stran / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Hilltop Service Corp. 1 Burial 2 X Cremation 3 Removal from State 1/4/11 Towson Maryland 4 Donation 5 Other (Specify) feonara didick set facility 5305 Harford Road B 21. Signatur of Funeral Service Licer Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4moraci Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) signed by the a d be detached f (I)ing in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not re 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No Yes 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🔲 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 5 Pending 24 hours after death. Funeral Director: A Investigation filled in by the Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/exinvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 3 🗆 within 2 To the I only one) 29b. Signature and little of certific License number . Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MURRANKA SMITH Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL KESVILL -OMESTAA10 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 20 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗸 F 412 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director CARROLL 1 Yes 2 No ELNERSBURG 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21784 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) KENNEDY Elementary/Seconday (0-12) College (1-4 or 5+) EACHERS H16H 0 HIDE Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ KATHERINE CZARNESKI MURRANKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5831 MELVILLERWAD ELDERSBURG-MO 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State ò permit. Page Department Important: It any injury or 12/2011 OLNEY, MO IORBECK MEM. PARK 4 Donation 5 Other (Specify) 22. Name and Address of Facility JN ZumBmn 1= H & mon Co. Signature of Funeral Service License 6028 SYKESVILLERY ELDERYBURG-MO 21784 23a. PerM criter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Betweer nset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 05 15 Due to (or as a consequence of Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2/1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suit Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21784 380 MCEVO 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number County of Death Examiner Baltmore Pice Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) MD Date of Birth **Funeral** Sex 1 ☑ M 2 ☐ F 213-32-2386 7/4/1935 Min MD 75 Yrs Director Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5148 Bonnie Acres Dr. 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗴 No Black, White, etc. 1 ☐ Never Married 2 🛣 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give White "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1,4 or 5+) Mechanical Engineer Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked ည Edna Ray Henry Stromberg Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.2</u> permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Jane Stromberg - Wife 5148 Bonnie Acres Dr. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) 1/13/11 5 Crest Lawn Mem. Gdn. Marriottsville, MD Signature of Funeral Service Ligensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Dust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NOMOC arcmone disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the aid be detached for Yes 2 No g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed should been 24b. Were autopsy findings available 24a. Was an page 2 autopsy performe prior to completion of cause of death? has certificate ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes ည 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one the 29b. Signa person who completed cau 30. Name and address of e of de 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

State Registrar EDMUND PIKARULL YOS

31. Date filed (Month, Day, Year)

They I Road Son SINO Cotharulles Zine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 11:59 Medical 4a Facility Name (if not institution, give street and numb Town, or Location of Death County of Death **Examiner** DURNIE Wash 8. Date of Birth (Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 □ M 2 💢 F Country)
Maryland Director 214-46-2344 64 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7517 Brightwater Beach Road 21060 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Baltimore, Maryland 21215-0030 Specify: 3 XWidowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ James Carson Gernert Mildred Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tran Terri R. Bennett (Daughter) 7517 Brightwater Beach Road Glen Burnie MD 21060 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cem.: 01/12/2011 Crownsville V.A. Crownsville, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryla 21. Signature of Funeral Service Licensee Maryland Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis eted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 XNo Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) and title of certifier erson who completed cause of death (Item 23a) (Type, Print) 1 0 201 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

			Plea	ase Type or Pri State of M									le.	
			For State Registrar	Otate of W	ai yiai ic		tificate of		and n	iorriai i iy	Reg. N	201	Butter 118	00222
			Decedent's Name (First, Middle)	e, Last)				2. Date of De	eath			3. Time of Death		
	Physicia Medic		Doris Mar					Jan.	4	20Î	ar 1	10:15p M		
need.	Examir		4a. Facility Name (if not institution Carroll Hosp	4b. City, Town, West				4	c. County of E Carro					
2	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las		If Under 1 Year Months Day		r 24 Hrs. Min.	8. Date of Bir	rth ay Year)	g.	Birthp	lace (State or Foreign
	Director		196-18-6592 Usual Residence of Decedent	X'	88	Yrs.			1	pril	10,	1922		Penn.
	/land f show ed at	tor	10a. State 10b. County	ltimore		Town or Loc	ation						1	0d. Inside City Limits
	Mar. 28a- notifie	jre			17111	Ters	Liot 71 O. I							1 Yes 2 X No
	ith the	Funeral Director	10e. Street and Number 19809 Gunpowder Rd.				10f. Zip Code 211				-	. Citizen of What Country? U • S • A •		
	ems ar mus	e l	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. V			rigin? (Spe	cify Yes or No-				an Indian,
9	fter de	by	1 Never Married 2 Mar	14 1/2 - 00:	No		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo Specify:					Black, White, etc.		
8	tural"	ted	3 ☑ Widowed 4 ☐ Divorced	Year or Dates.			ent's Usual Occ		· .		_	Specify: White		
15-	72 hc n "na Medic	Completed by	(Specify only highe	nt's Education est grade completed)	grade completed) ((upation e <i>during m</i> o: d)	ing 16b. Kind of Busines			ess Inc	lustry	
21215-0036	within giene. er tha , the I	ပိ	Elementary/Seconday (0-12) College (1-4 or 5+) Housewife							Homemaker			r	
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.								ner's Name (First, Middle, Maiden Surname) ora Virginia Kebil					
lary	should and N is ma auma		19a. Informant's Name/Relations	hip (Type, Print)			g Address (Stree							
≥ 5	and 2.		Nancy Shamer	- daughter			9 Gunp	owder						
Baltimore,	ge 1 ant of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from State	ce/	metery, crem	sition (Name of natory or other p			ate		Location - City		
Iţi	artmer ortani injury		4 Donation 5 Other (S		New		eran C							r, MD. hapel P.A
Ba	permi Depar Impoi any ir		J. Hend &	elix			96 Cha							
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death.							-1077		Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	a			5eros19	S .						Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):								, , ,
أور		ıer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a conseque	nce of):							+	
	rted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events			,								
	executed an and rial-transi	_	resulting in death) Last	Due to (or as	a conseque	nce of):								
09	ath certificate be executed attending physician and for use as the burial-transit	Physician/Medica		d									_	
Box 68760	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	CV.				•		00 D /	:	
×o	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregna Other (specify)	ncy				23d. Date of Month		ny Day Year
. B	the de by the ached	hysi	g Unknown	g 🗌 Unknown										
P.O.	Attending Physician: The law requires that the death certificate be ar death the strength of the actor. After this certificate has been signed by the attending physici cycor. After the cuterior, page 2 should be detached for use as the but the funeral director, page 2.	by P	Part II. Other significant condition	ns contributing to death b	ut not resul	ting in the u	nderlying cause	given in Part	: I.					e cause of death?
rds	require been si should b	Completed								1 🗆				ably 4 Unknown
00	has be	mple						. , ,,		24a. Was auto		24b. Were prior deat	to cor	sy findings available npletion of cause of
A.	ician: The la certificate ha ector, page		25. Was case referred to medical				20	Disease f Dec	nth (Chaole	1 Yes				2 🗌 No
/ita	ysician: is certific director,	To Be	examiner?	Hospital:	ent 2 \square E	R/Outpatien		Place of Dea		ne 5 🗆 Resi	dence	6 Other 6	necify)	Hospice
of Vital Records,	g Physical this	te: T	27. Manner of Death	28a. Date of inju	ry 2	8b. Time of injury	28c. lnj			28d. Describe			occiny/	
on	Attending or death. ector: After by the funer	fica	1 Natural 5 Pendir 2 Accident Investig 3 Suicide 6 Could	gation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2	No					
.≥		Certificate:	4 Homicide determ			ie, farm, stre	et, factory, office			28f. Location (City or Tox			Rural	Route Number,
_	To the Hospital or within 24 hours aft. To the Funeral Dir completed filled in	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of ex Nurse Practioner: To the	xamination a	and/or investi	gation, in my opi	nion, death c	ccurred at	the time, date a	and plac	e, and due to t	he cau	se(s) and manner stated
	To the within 2 To the comple		only one) 3 ☐ Certifying 29b. Signature and title of certifier		n dest or my r	riowieage, a	29c. Licer	se number		e, and due to tr		ate signed (Me		
				Jone (W		10	00599	43)2	mody	6	,2011
Q	101		30. Name and address of person	who completed cause of di	eath (Item 2	3a) (Type, P	rint)	uje	307	مزدمى	7117	1570	M	0 21157
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	re		,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hannah Vera Stevens January 4, 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Care Carroll Lutheran Village Center Westminster Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** 1 - M XXF Months Hours **Director** 88 218-14-6845 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XXNo Carrol1 Westminster 10e. Street and Number 10g. Citizen of What Country? Funeral 205 St. Mark Way Apt. 129 21158 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? 1 ☐ Yes **X**XNo Black, White, etc. þ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5 +YWCA Executive Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Lawrence S. Stevens Isabe1 (Jacquette) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Garman / Nephew 3918 Castlebar Dr. Glenwood, MD 21738 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel 1/7/11 Rock Hall, MD emetery and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fundral Service Licenses 1605 Reisterstown Rd. Owings Mills, MD21117 e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) Advanced Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam or Attending Physician: T e law equires that the death certificate be executed Cause (Disease or imjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day Year 1 Yes No 9 Unknown Pregnant at time of death een signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, HTN, GERD 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an pege 2 s Jas performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) B B examiner? Hospital: Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death. I Director: After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No the 1 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after of To the Funeral Direct completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ss of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ TREVEY. MILDINGO ELATINE 1:14 PM 20/1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hours COLLABIA HOWAM COUNT HESPIDAL 12 KERESU-If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 13. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Hours 1 M 2 X F Months 88 219-16-0381 Maryland Director Usual Residence of Decedent or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director MD 1 ☐ Yes 2 X No Howard Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 8610 Snoden River Parkway 119 21045 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 XXDivorced Completed White Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Radio Station Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Charles L. Oursler, Sr. Ethyl DuVall Informant's Name/Relationship (Type, Print)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles L. Oursler, Jr. (Brother) 7746 Waterloo Road Jessup, MD 20794 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 1/6/2011 Elkridge, MD 21. Signature of Funeral Service Licenses Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that divided shock, or heart failure. List only one cause on sach line Immediate Cause (Final aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death VENTRICULAR Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA ည 1 Inpatient 2 ER/Outpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1-Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one within 2 To the I the 29c. License number 50538 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIHALLE

State Registrar 31. Date filed (Month, Day, Year)

Darke

32 Registrar's Signature

DHMH 17 Rev 7/2009

11-00034

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Alicia Taylor 1- For State Certificate of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Month Day January 1, 2011 01 1440 hrs Madical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 4718 Greenspring Avenue Apt. # 2 If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Min Director Country) MA Vland 1 M 2 F Usual Residence of Decedent 10b. County Oc. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 123a or 28a-f show notified at once. Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 Married 1 Yes 2 1 No If Yes, Give Yeer or Dates: 1 Yes 2 No specify: 4 Divorced 至 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) nore, MD 21215-0036
"ages I and 2 should be filed within 72 hount of Health and Mernal Hygene.

If Iliem 27 is marked other than "...o Elementary/Secondary (0-12) College (1-4 or 5+) unemployed 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carter Taylor 19b. Mailing Address (Street and Number or Real Route Number, City or Town, State, Zip Code) 19a. Info mant's Nam Relationship (Type, Print) Latrobe SMHNZY 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State 1 Burial Cremators land 13 4 Donation 5 Other Specify 21. Signature of Funeral/Service License proximate Interva Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart **Physician** Between Onset and failure. List only one cause on each line **iMedical** Death Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical MENDED 23a,pt.II,27,28a-f per me g915 5-9-11 vt X UNPENDED of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Year 1 Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis of Liver Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Natural Division 1 Yes 2 X No Pending fd 1-1-2011 unknown unknown ţ 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4718 Greenspring Ave. Apt. #2 Baltimore, Md. filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined 4 Homicide residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated S 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Şignature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. January 2, 2011 allente 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 0.201

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Quintin Royston Tracey 2:00p 201 🛚 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Nursing Center Carrol1 Sykesville If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 2 1922 Months Days Hours Min. **Director** 217-12-2584 88 MD Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Carrol1 Sykesville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6518 Monroe Avenue 21784 USA with 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 X Yes If Yes, Give ģ 2 No WWII Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse welder 10 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မှ Kenneth N. Tracey Mary Bossom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Mrs. Pauline Tracey (spouse) 6518 Monroe Ave., Sykesville, MD 21784 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of F
Important: If ite cemetery, crematory or other place ŏ 1 XBurial 2 Cremation 3 Removal from State 1/10/201 Old Oakland Cemetery Sykesville, MD injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel any MOO764 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). sician and burial-transit requires that the death certificate be executed Cause (Disease or impur that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been significant Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 PINO ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural injury 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier signed (Month, Day, Year) Taleel 2011 all sus

State Registrar 31. Date filed (M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

agriculture of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Lee Thompson 11:05 PM January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Nursing Home -Woodbridge Catonsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 07/16/1923 1 XM 2 □ F Months 215-16-6209 Director Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** the Medical Examiner must be notified Maryland Baltimore 1 Yes 2 XNo Winsor Mill 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a 7302 Dooman Road United States 21244 items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. è þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event the Many injury or other traumatic event the Many injury or other traumatic event the Many injury or other traumatic life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Buyer Government Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John B. Thompson Jenine Kerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Weber - Companion 7302 Dooman Road Winsor Mill, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 01/08/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore. Maryland 21229 Part 7. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure (Lis) only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mi disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit Due to (or as a consequence of) resulting in death) Last signed by the attending physician a be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown P.0. Part II. Other significant conditions contributing to ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ascu Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1-- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Exclaw Inme 821 31. Date filed (Month, Day, Ye State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ noru John Ε. Towles Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death ounty of Deat Glen Mnie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Sex HXIM2□F Months Days Hours Min 83 **Director** 220-20-2117 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Pasadena 1 Tes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 8001 Middlebury Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Y Yes 2 □ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after on the sith and Mental Hygiene. Baltimore, Maryland 24215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " the Mr Elementary/Seconday (0-12) College (1-4 or 5+) 12 Inspector Westinghouse is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Meade Towles Margaret Pasterfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other to once, Mr. John B. Towles / Son 3395 Sudlersville South Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crestlawn Mem. Garden 01/11/2011 Marriottsville, MD 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ဂ 1 Yes Other: 1 🕱 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 5 Pending work? 2 🗆 No Accident Investigation Could not be completed filled in by the Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 07 Registrar DHMH 17 Rev 7/2009

11-00105 Linda Vargas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nda Vargas	State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death Registrar		2011 g. No.	00230					
Physician/ edical Examiner	1. Decedent's Name (First, Middle,Last) Linda Ann Vargas	Date of Death Month January 3,	Day Year	3. Time of Death 2204 hrs					
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore		4c. County of Deat	n					
Funeral Director	5. Social Securify Number 213-66-6897 6. Sex 1 M 2 X F 56 Yrs. 6. Sex 1 M 2 X F 1 M 2		1954 Forei	thplace (State or gn Minnesota buntry)					
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
-f show	MD N/A Baltimore 10e. Street and Number 10f. Zip Code	110	og. Citizen of What Cou	1 X Yes 2 No					
ath with the Maryland titems 23a or 28a-f show of the notified at once.	3131 Orlando Avenue Apt.2 21234	USA							
유 교립 그	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Xno		White, etc.	- American Indian, Black, , etc. white					
nurs after ntural", aminer d by	3 X Widowed 4 Divorced of Pates: 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of volume in the property of the property		Specify: W 16b. Kind of Business/						
15-0036 filed within 72 hours after and 14 Hygiene. Ed other than "natural", of the Medical Examiner are Completed by F	Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker		At Home						
21215-0036 2uld be filed within 7 l Mental Hygiene, marked other than it event, the Medical TO Be Comple		es Pa	arr						
MD 21 d 2 should th and Me n 27 is max numatic cv	19a. Informant's Name/Relationship (Type, Print) Katrina Bigelow-daughter 19b. Mailing Address (Street and Number or F 19 Odeon Court-Parkvi.								
Fe, an f. Hea	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, Evants Place) 20c. Place of Disposition (Name of cemetery)	Date 5 ,2 011	20c. Location - City or Forest Hill,						
Baltimo permit. Page: Department o Important: injury or oth	21 Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral C 8800 Harford Road	Chapel -Parkvi	and Crema lle,Marylar	ation Ser. nd 21234					
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease a. Mixed drug (methadone & tramadol) in	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death					
Examiner	or condition resulting in death) Due to (or as a consequence of):								
ted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
ecuted and transit	events resulting in death) Last Due to (or as a consequence of): d.								
be ex lician urial	IF FEMALE: 23a,27,28a-f,per ME G913 3/3/11	TT	23d. Date of deliver						
Records, P.O. Box 68760 The law requires that the death certificate the law requires that the death certificate the base has been signed by the attending physioge 2 should be detached for use as the business.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	incy		Day Year					
ires that the designed by the detached for the detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?					
of Vital Records, P. ag Physician: The law requires the fact this certificate has been signed rector, page 2 should be don't To Be Completed b.		24a. Was a autops	an 24b. Were at	utopsy findings available completion of cause of					
	25. Was case referred to medical 26.Place of Death (Check	1 ✔ Yes 2		es 2 No					
F Vital Physician: rt this certification; ral director, To Be (examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursin		Residence 6 Othe	r:					
ion of tending Pheath. tor: After the funeral the funeral ation: T									
Division of Vital Bospital or Attending Physician: 24 hours after death. Fueral Director: After this certifully filled in by the funeral director. al Certification: To Be		<u>2nd F1oo</u>	or, Parkvil						
5 P P P P	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause at the time, date a	e(s) and manner as stated and place, and due to the	ted. ne cause(s)					
To with To com	29b. Signature and title of certifier O.C.M.E.		29d. Date signed (Mo	onth, Day, Year)					
8	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltim	nore, MD 212	223						
State			OCME						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Florence D. Vogel Physician/ Month Day 2011 3:45p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 512 Cedar Avenue Essex Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year, Country) 212-28-9433 78 **Director** July11. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director MD Baltimore 28a-f Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be 23a Funeral 512 Cedar Avenue 21221 USA er than "natural", or items: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed 9th Day Care Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be Baltimore, Maryland and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George HArtman Helen Jesionowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Brinkmeier /daughter 326 Maple Avenue Baltimore MD 21221 Health a 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Oak Lawn Cemetery 1/10/11 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of ESSEX 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 19901 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 X No 1 Tyes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Kertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 2300 Registrar's Signature State

Registrar

11-00020 Joyce Whitaker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #200 after Maryland / Department of Health and Mental Hygiene

Joyce willtaker	1- For S		5	tate of	Maryia		partme <i>ertifica</i> i			ind N	/lental Hy	ygiene	Reg. No	201	-	8023
Physician Medical Examine	1. Dece		First, Midd	ile,Last)	ev	-						2. Date of D Month January	eath Day	Year		3. Time of Death 1350 hrs
G. I			not instituti dway Stre	_		mber)			City, Town, Baltimore		ation of Death			c. County of	Death	
Funeral Director	215.	N Security N	5980	6. Sex	2× F	7. Age (In yr	s. last birtho		f Under 1 Y Months D	_	Under 24Hrs. Hours Min.	- ·	Birth (MI)		oreign	nplace (State or ntry) <i>NC</i>
yland -f show any Once	10a. Sta	esidence of	10b. County				ity, Town or Ba <i>Hi</i>	MOV								10d. Inside City Limits
	92	5 N.		dway	Stre	et A	pt 30	1	of. Zip Code	20	5		. 10g. Ci	tizen of What		ry?
	3 1	1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced or Dates:					,	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 Yes 2 No specify: a. Decedent's Usual Occupation (Give kind of work)					n, etc.) White, etc. Specify: Black			
2 hour 2 hour LExath	Elem	entary/Seco	ndary (0-12)		College (1		16a. De	ring most	Jsual Occup of working li	ge. DO	NOT use retir	ed)	1	Kind of Busin	Hess/Inc	dustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		aria	ne/Relations	bita	Ker		10b	Mailing Ad	drags (Sta		Ronn Ronn	nie (ho	IVIS		
re, MD 2 1 and 2 shou Health and M fitem 27 is nor traumatic	20a. Me	nice thod of Disp	osition (olen	an	Coysi	/	05 (old 1	Hon		Date	Ba/7	TMOVE Location - C	1	1d. 21206
Baltimore, MD 21214 permit. Pages I and 2 should be fil pergraphent of Health and Mental I. Important: Witem 27 is marked injury or other traumatic event, in	4 🗆	enation 5	Cremation Other Sieral Servi	pecify:	Removal fro	m State	Wes	ern	and Addre		_ 1/8	7/2011 FC	成 4	a Himo	re,	Maryland
Physician /Medical	23a. Par	I. Enter the	disease, or one cause	complicati on each li	ions that ca	used the dea	ith. Do not e	va u	ode of dying	g, such	as cardiac or	e F. S respiratory a	rrest, sh	CL/HM ock, or heart	re,	Approximate Interval Between Onset and
Examiner		ite Cause (F	inal disease g in death)			sclero		Cardi	ovascı	ular	Disea	ise		<u>. </u>	\dashv	Death
led nsit Examiner		tially list con eading to imp Enter Under or injury the esulting in d	nediate lying Couse at initiated	C		consequence										
60, ate be executed bhysician and bhysician - trans	X U	NPENDED		d AM	MENDED	23a,2	7 per	me g	912 2	-25	-11 vt	-			\dashv	
Division of Vital Records, P.O. Box 68760, the Houpital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and opplietly filled in by the funeral director, page 2 should be detached for use as the burial - transit sidned in the funeral director. Be Completed by Physician/Medical Fx	IF FEMA 23b. Was past	decedent p	regnant in th	1 4	Live bir	nt at time of	2	Fetal d	eath 3 (Specify)	Ec	topic pregnan	су	23	d. Date of de Month	livery Day	y Year
P.O. Best hat the digned by the detached	5	ther signifi	cant conditi			death but no	t resulting in	the under	lying cause	given i	n Part I.					e cause of death?
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach n: To Be Completed by P												24a. Wa auto	s an opsy ormed?	24b. Wer	e autor	osy findings available apletion of cause of
F Vital Rec Physician: The ar this certificate ral director, page To Be Con	25. Was exam	case referre iner? Yes 2	d to medical	Hospit	tal: 1 In	patient 2	ER/Outpa	atient 3	26.Plac	Other	ath (Check or		Reside	nce 6 🗸 C		cene
ion of tending Pt eath. for: After the funeral		er of Death latural	5 Pend	ling	28a. Date o (Month, I	f Injury Day,Year)	28b. Tim	e of Injury		•	Vork? 2	Rd. Describe	how inju	ary occurred		
Division o vapital or Attending hours after death. Ineral Director: After the filter in by the function: Certification:	2	lomicide	6 Could	1 HOLDE	28e. Place (Specify)	of Injury - At	home, farm,	street, fa	ctory, office	building	g, etc. 2	8f. Location or Town,	(Street a State)	nd Number o	r Rural	Route Number, City
To the How within 24 h To the Fun completely		2 🗸	ledical Exar	niner:On t and	To the best the basis of manner sta	examination	edge, death and/or inve	occurred a stigation,	nt the time, on n my opinio	date and n, death	d place, and d	ue to the cau	ise(s) an e and pla	d manner as ce, and due t	stated. o the c	ause(s)
		Lange	tle of certifie	me (Gell				29c. Licen	se num .M.E.	ber			Date signed uary 2, 20		, Day, Year)
) -	Mar	garita Ko	rell MD.		ant Medi		iner 900	0 W. Ba	Itimore S	Street,	Baltimore	, MD 212:	23			
State	31. Date	filed (Month	Day, Year)	0044	32. Reg	istrar's Signa	ture	1								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	•			Mental Hyg	iene	1	0.0000	
			Registrar	Cen	tificate of D	eath	1	eg. No. 🚄	William III	000233	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Deat Month		Year	3. Time of Death	
	Medic		Ellen Shropshire	Wyatt			January)11	12:44 PM	
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County		. ,	
			Glade Valley Nursing Center 5. Social Security Number 6. Sex 17. Age (In vrs. last b	- look to a to a col	Walker If Under 1 Year	SV111E If Under 24 Hrs.	I a Data de Piat		rederi		
	Funeral Director		1 DM O NTE	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 19	Year)	_Count		
			219-48-8585 1 90 Usual Residence of Decedent				Loury 15	, 1920	Texa	as	
	land show dat	ō	10a. State 10b. County 10c. City, To	wn or Loc	ation				11	0d. Inside City Limits	
	Aaryla 8a-f tifiec	rect	MD Frederick Uni	on B	ridge					1 ☐ Yes 2X No	
	the to or 2	٥	10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?			
	with s 23a ust b	Funeral Director	12529 Molasses Rd.			21791		U.S	.A.		
	death item	필	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-		e - America		
9	", or amir	by	1 Never Married 2 Married 1 X Yes 2 No		Yes 2 No		1 110011, 0101,		ck, White, e	etc.	
Maryland 21215-0036	s filed within 72 hours after death with the Maryland Ital Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed	Year or Dates 1943-48					Specify	White		
5	72 ho n "na ledic	ed l	15. Decedent's Education 16 (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done di	ition uring most of worl	ring	16b. Kind of B	lusiness Ind	lustry	
12	thin ene. thar he M	등	Elementary/Seconday (0-12) College (1-4 or 5+)		NOT use retired) emaker			O 1	3.		
20	ed wi Hygid Sther	Be (17. Father's Name (First, Middle, Last)	HORK	allaket	18 Mother's Nan	ne (First, Middle, N	Own I			
a	be fill ental rked c	힏	Levingston Lindsay Shropshire						<i>c)</i>		
$\overline{\geq}$	e 1 and 2 should be file of Health and Mental I fitem 27 is marked or r other traumatic eve			Ob. Mailin	Address (Street a		Linn McM		State Zin C	· · · · · · · · · · · · · · · · · · ·	
S	2 sh Ithar 27 is trau				`						
စ်	l and f Hea item other		20a. Method of Disposition 20b. Place	of Dispos	Molasse ition (Name of		Date Date	20c. Location			
Baltimore,	Page nent of ant: If ant: If ury or				atory or other place				·		
₫	nit. Partme ortar injur e.		21. Sign time of Funeral Service Ucensee		y Cremati Name and Addres			Sykesv		MD	
Ř	permit. Page 1 a Department of H Important: If itel any injury or off		Marries of Garthey		0 Church	IIa	rtzler F				
			23a. Part 1. Enter the disease, or complications that caused the leath. Do						21776	Approximate	
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	20	1.1	,			,	Interval Between Onset and Death	
7	Medical		disease or condition resulting in death) a. Die to (or as a consequence)	ver	140				- 1	yeur	
	Examiner		Se to the as a consequence	.c (1).	, de	susi	_		- 1	Acar	
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or a consequence	e of):						7-20-5	
	ted d insit	Examiner	Cause, Enter Underlying Cause (Disease or linjury								
	be executed sician and burial-transi	EX	that initiated events resulting in death) Last C. — Due to (or as a consequence	e of):							
20	ate be executed hysician and the burial-transit	dical	d								
3/6	certificate anding physuse as the	Ved	IF FEMALE:					1			
200	endir use	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		Ectopic pregnancy	ı/		23d. Da	ate of delive	ery	
POX	death	sici	1 Yes 2 No 4 Pregnant at time of death		Other (specify)	,		Me	onth	Day Year	
- -	t the by the tache	Phy	9 🗆 Onknown								
Ţ.	s that gned se de	by	Part II. Other significant conditions contributing to death but not resultin	ng in the ur	nderlying cause give	en in Part I.		1		e cause of death?	
Records,	equire sen si ould	Completed					1 □ Y	es 2 Nó	3 ∐ Prob	oably 4 🗆 Unknown	
o	aw re las be	nple					24a. Was a autops	SV	prior to cor	nsy findings available ripletion of cause of	
e Y	The late h	Con					perfor		death?	2 🗆 No	
Vital	cian: ertific ector,	Be	25. Was case referred to medical examiner?		-	ice of Death (Chec	k only one)	7.1			
<u>=</u>	hysin this c	မ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/			4. Nursing H	ome 5 🗆 Reside	ence 6 🗆 Oth	er (Specify)		
<u></u>	ing F	ate:	27. Manner of Death 12 Natural 5 Pending 28a. Date of injury (Month, Day, Year)	o. Time of injury	28c. Injury work:	?	28d. Describe ho	w injury occur	red		
Division of	tend death tor: / the f	tific	2' Abcident Investigation			Yes 2 No					
≦	or A	Certificate:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	tarm, stre	et, factory, office		28f. Location (St City or Town		er or Rural	Route Number,	
	ours ours eral filled	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledg	e death o	coursed at the time	date and place a	nd due to the cau	ee(e) and mann	er as stato	d	
	e Hos 24 h e Fun leted	ledi	(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my known	d/or investi	gation, in my opinio	n, death occurred a	at the time, date an	d place, and du	ie to the cau	se(s) and manner stated.	
	To the Hospital or Attending Physician: The law requires that the death certifica for thin 24 hours after death. Within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Σ	29b. Signature and title of certifier	ougo, u	29c. License			gd. Date signe			
P			1 duk		N	2-1251	6	TA	N 3	3 2011	
			30 Name and address of person to complete cause of death (Item 23a	a) (Type, P	im) 1 -1	1	CA.	4 1		10	
			MITHEN I GO SON MD. 14	15	ANEY	THE	rkei	M) 7	41702	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.	backer						
	negisti	:11	WITH THE CULT BASE	1- 1	All and a second						

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician: The law requires that the death certificate be executed Completed After this certificate has been Certification:

27

2 3 4 29a (Ch Medical

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day,

t II. Other significant conditions	contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?									
			1 Yes 2 No 3 Probably 4 Unknown									
			24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No									
Was case referred to medical examiner?	26.Place of Death (Check only one) pital: 1											
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	ing Home 5 Residence 6 ✔ Other: Scene										
Manner of Death Natural 5	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred									
Accident 5 Pending Investigati			unknown									
Suicide 6 X Could not determine	-	tory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 757 203rd St.									
Homicide determine	(Specify) house		Pasadena, Md.									
Certifier 1 Certifying Physici	ian: To the best of my knowledge, death occurred at	the time, date and place, an	d due to the cause(s) and manner as stated.									
o ► Medical Examiner	r:On the basis of examination and/or investigation, in	my opinion donth assurred	at the time, date and place, and due to the agree(a)									

29c. License number

O.C.M.E.

en Onset and

Year

29d. Date signed (Month, Day, Year)

January 5, 2011

Death

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JANUARY 5, 2011 5:30 A M JETHRO ALONZO WOLFORD JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV. 21, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 🔀 M 2 🗆 F 1918 West Virginia Director 92 232-22-6076 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Harford Bel Air 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21014 1300 Locust Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ∐Yes 2 🔼 No Specify þ Specify. White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Freight Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle (nmn) Snyder Jethro Alonzo Wolford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1300 Locust Ave., Bel Air, MD 21014 Frances Maria Boyce / Daughter permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp | 1-6-11 Towson, Maryland 4 Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an ach line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 Ano 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated. 29b. Signature and title of certifier H0062765 January 5,201,
ad cause of death (Item 23a) (Type, Print)

D0500 Upper Chesapeake Dr. Bel Air, Mp 21014

32. Registrar's Signature (hg 30. Name and stress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 07 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C911 1/07/2011 THE State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 3 Day 2011 Year Physician/ 1:45 P. Doris E. Welsh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air Upper Chesapeake Medical Center 8. Date of Birth
(Month, Day, Yo If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2XXF Hours Marviand 1921 Director 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County aţ Director r 28a-f sl notified 1 Yes 2 X No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a Funeral 294 Canterbury Road 21014 United States Apt J. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 1 Never Married 2 Married Specify: White 1 Yes 2 X No Specify: Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Loyola College Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mabel Burgan Albert E. Nonemaker 19a. Informant's Name/Relationship (Type, Print)
Marjorie Strama / Daughter 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Boggs Road Forest Hill, Maryland 21050 Department of Health ar Important: If item 27 is any injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. 20a. Method of Disposition 20c. Location - City or Town, State Jan. Date 1 Eburial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one gause on each line nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last anding physician and use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy 1 Yes 2 No Yes 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) **Division of Vital** Be examiner? 1 \square Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA ဂ္ within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 \square Pending 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN USHA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20a-c&22perFH, G912, 2/17/2011, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 1 20111 Physician/ Alice Theresa Woods 5:45 01 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9512 Linville Avenue Howard Laurel Social Security Number 6. Sex . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🔀 F Months Country) 89 Director 013-16-3123 MA 07/09/1921 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Laurel 1 ☐ Yes 2 🙀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 9512 Linville Avenue 20723 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: White 3 ▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Federal Elementary/Seconday (0-12) College (1-4 or 5+) Government Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Naeema Saab <u>Lewis M. Z</u>aher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9512 Linville Ave.,Laurel, <u>Theresa Woods (Suite</u> MD20723 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Whiteer Crematory place) West Warwick, RI 4 Donation 5 Other (Specify) Med Cure 21. Signatur Funer I Service Licensee Drglen on Highland en Buroie, and umberland, I 7221 Grayburn Corporate Cure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final set and ath ₽nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine after death.

Director: After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2. Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Dav Year Yes 1 ☐ Yes 2 µ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ว 24 hours a e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN Registrar

Sind.

Jack Titus MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) State

30. Name and address if person who completed cause of death (Item 23a)

32. Registrar's Signature

ORIGINAL

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Registrar

January 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ezikah Wilson	State of Maryland / 1- For State Registrar	Department of Certificate of			2 0 mg. No.	00239					
Physician/	Decedent's Name (First, Middle,Last)		F	Date of Deat Month	h Day Year	3. Time of Death					
ledical Examine	HEZIKAH WILSON III 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of D	January 2,	2011 4c. County of Death	2017 hrs					
	Good Samaritan Hospital	1	Baltimore	Death	N/A						
Funeral	·	(In yrs. last birthday)	If Under 1 Year If Under 2	4Hrs. 8. Date of Birt	h/MM/DD/YYYY 9 Birt	hplace (State or					
Director	215-04-3923 1XM 2F	38 Yrs.	Months Days Hours	Min. 04/05/	1972 Foreig	nMARYLAND					
	Usual Residence of Decedent			0.7057							
w any	10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits					
Maryland 28a-f show 1 at once. ector	MARYLAND N/A		1 XX Yes 2 No								
th the Maryland 13a or 28a-f sho notified at once.	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?					
ith the 23a o	5624 PLYMOUTH RD.		21214 s Decedent of Hispanic Origin'	O Caracife Van an Na	U.S.A.	nen Indian Block					
or death with to or items 23s	1 XNever Married 2 Married Armed Forces?	If Ye	es, specify Cuban, Mexican, Pr		White, etc.	cari indiari, black,					
iter de	3 Wildowed 4 Divorced in res, Sive real	XX No 1	Yes 2 X No specify:		Specify: BLAC	CK					
ours aft atural" camine	or Dates: 15. Decedent's Education (Specify only highest grade company)		's Usual Occupation (Give kin		16b. Kind of Business/I	ndustry					
6 72 hc cal E	Elementary/Secondary (0-12) College (1-4 or 5	+)	ost of working life. DO NOT us	e retired)							
5-0036 ed within 72 hour 1ygiene of ther than "natu the Medical Exan Completed	12th grade	DIS	SABLED(Autism)		N/A						
Hiled Hyge of the control of the con				lame (First, Middle, M	laiden Surname)						
21215-0036 total be filed within 7 d Mental Hygiene. s marked other than its event, the Medica TO Be Comple	ARCHIE WILSON 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	AMN Address (Street and Numbe	IE MACK r or Rural Route Num	ber, City or Town, State,	Zip Code)					
MD and 2 sho alth and 27 is sumation	Annie Wilson/Mother	5624	Plymouth Rd.,	Baltimore	, Md. 21214	+					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Witem 27 is marked other than "natural", or items 23a or 28a-fahe injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition		tion (Name of cemetery,	Date	20c. Location - City or	Town, State					
Baltimore, permit. Pages 1 an Oppartment of Hea Important: Wite Important: Wite Important: Wite Impury or other tr	1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other Specify:	METRO CRE		01-06-11	BALTIMORE,	MARYLAND					
alti mit. partm porta iury o	21. Signature of Funeral Sarvice Licensee	22 N	ame and Address of Facility LIAM C BROWN	COMMUNITY	FUNERAL HON	Æ P.A.					
	(Courie	120	6 W NORTH AVE	NUE		Approximate Interval					
Physicián /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Examiner	Immediate Cause (Final disease or condition resulting in death)					Death					
	b	quence or):									
Jer Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consection)	quence of):									
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
	d.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
ian a	UNPENDED AMENDED										
760, cate be physic the bur	IF FEMALE: 23c. If yes, outcome	e of pregnancy			23d. Date of delivery						
tox 6876(eath certificate attending physfor use as the brisinal/Metrician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at ti	imp of do oth	al death 3Ectopic pr	egnancy	Month D						
b. Box 6876 the death certificate by the attending phy ched for use as the I Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	ime of death 5 Oth	er (Specify)								
that the ned by the detached	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I	23e. Did tob	pacco use contribute to t	he cause of death?					
- S				1 Yes	2 No 3 Prob	ably 4 Unknown					
Records, The law require ficate has been sig page 2 should be Completed			opsy findings available ompletion of cause of								
he law ate has age 2 sl				perform 1 ✓ Yes 2	ned? death?	_					
tal Recition: The certificate ector, page	25. Was case referred to medical		26.Place of Death (Ch	eck only one)							
o de la si si Si	examiner? 1 Yes 2 No Hospital: 1 Inpatien	t 2 🗹 ER/Outpatient	3 DOA Other N	ursing Home 5 F	Residence 6 Other:						
ding Ph ding Ph After t funeral	27. Manner of Death 1 Natural 5 Panding Jan 2, 2011	y 28b. Time of In 1930 hrs		Subject was	ow injury occurred shot						
Division or spital or Attending hours after death. Increase Director: After filled in by the function: Certification:	2 Accident Investigation		1 Yes 2 ✔ No	,							
Divis pital or A ours after ceral Dire filled in b	Suicide Could not be		t, factory, office building, etc.	or Town, St	treet and Number or Rur ate)						
	29a. Certifier	-	and at the time alone and alone		Road, Baltimore, MI						
Divi	(Check only one) 2 Medical Examiner: On the basis of exam	-									
To wit To con	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)					
	Jamel Sunthall not)	O.C.M.E.		January 3, 2011						
	30. Name and address of person who completed cause of de	ath (Item 23a)									
3	Pamela E. Southall, MD Assistant Medic		W. Baltimore Street, B	altimore, MD 21	223						
State		s Signature	all								
Registrar	UNITO I ZUIII JOSANA	- 1									

DHMH 17 Rev 1/2001 OCME 2006 OUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 55/4 M Physician/ Bay_ 201 ICTOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL EANDALLS TOWN BACTIMORE NORTHWEST CENTED) If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours 0170871923 87 **Director** 135-16-7964 NY Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8402 WINANDS ROAD 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-003่ง 1 ☐ Yes 2X No Specify: WHITE 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL SECURITY DISABILITY CONSULTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MOLLY MINOGA MOSES YARMIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8402 WINANDS ROAD, BALTIMORE, MD SELMA YARMIS/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) BALTIMORE NATIONAL 01/06/2011 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION CSSENTIAL Sequentially list conditions. Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Yes 2 L cate has been signed by the page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KINSON'S DISEASE 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy PETIPHERAL 2 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature

State Registrar

DHMH 17 Rev 7/2009

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 Year Physician/ Day 09 3:58 A M THELMA Μ. ALLEN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE PARKVILLE OAK CREST CARE CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Months Days 1 M 2 XF 0377371920 MARYLAND 90 Yrs. **Director** 215-18-6465 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ី No BALTIMORE PARKVILLE MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral U.S.A. 8820 WALTHER BLVD. 21234 #314N "natural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 XNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTING CLERK BALTO. GAS & ELEC. permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROTHENBERG ELIZABETH THOMAS S. ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 FRANK G. LIDINSKY, ESQ. 8600 LaSALLE ROAD, SUITE 320, BALTO., MD timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State OAK LAWN CEMETERY 1/13/11 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Fundamervice Licenses 22. Name and Address of Facility
LILLY & ZEILER INC.
1901 EASTERN AVENUE FUNERAL HOME BALTO MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ mphysema disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a sonsequence of attending physician and for use as the burial-transit Rbilita or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Rmentic Records, P.O. Box 687 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 1 Unknown ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has a in by the funeral director, page 2. performed? Yes 2 No 2 🗆 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Yes 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital 24 hours a 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie H0052065 JUNUARY 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville Maryland 21234 8834 Walther Blud, Korald Je+ treys 32. Regis ar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Emanuel Stavros Anagnostiadis 6:30 P M 2011 January 8 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 👿 M 2 🗆 F Months Hours Min (Month, Day, Egypt Director 80 579-56-2108 November Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Potomac Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10817 Hob Nail Court 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify Specify: Greek 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry withing With the West (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maitre'D Restaurant 12 marked other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eventone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carnation Stamatakis Stavros G. Anagnostiadis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10817 Hob Nail Court, Potomac, Maryland 20854 Sophia E. Anagnostiadis/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M0136023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ End Stage Renal Disease disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated event resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Year Dav 9 🗖 Unknown 9 Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ğ Clostridium Dificile Colitis, Non-Functioning Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Arteriovenous Fistula, Anemia Due To End Stage 24a. Was an page 2 s performed' Renal Disease, Dementia, Coronary Artery Disease certificate 2 🗌 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 ី No မ Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After the 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 🗀 Pending 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t 29d. Date signed (Month, Day, Year) 01/09 2011 Marall D68405 deess of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20817 David Guevara-Nieto, M.D. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

 $\overline{\infty}$

EMANUE

ANAGNOS

			For State Registrar	State of	Maryland		artment			and M	ental Hy	gien Reg. N	2011	002	43
	Physici	an	1. Decedent's Name (First, Middle, La	ist)							Date of De Month	D	ay Year	3. Time of [
	/Medic	cal	June Rupert Alle				4h City 1	OWD OF	Location o		Januar		5, 2011 c. County of Death	11:42	A M
	Examir	er	Asbury Assisted		Jeij				sburg				Montgome		
	Funeral		5. Social Security Number 6.	Sex 7.	. Age (In yrs. la	st birthday)	If Under Months		If Under 2		8. Date of Bir (Month, D			nplace (State or untry)	r Foreign
	Director		258-22-7722	1□ M 2🌠 F	94	Yrs.	WOTTERS	Days	Tiodis	IVIIII.	Octobe	r 15	, 1916 Ge	orgia	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City	y Limits
	Maryl f sho	tor	Manysland Mantaon	0.227	Cod	thers	hura							1 XYes	2 🗆 No
	n the	Director	Maryland Montgon 10e. Street and Number	iery	Gai	LHEIS	10f. Zip	Code				10g. C	Citizen of What Co	untry?	
	th wit		333 Russell Avenu	ıe, #110			2	0877	7			Un	ited Sta	tes	
	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	. 13. \	Nas Deced f Yes, spec	ent of Hi fy Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - Amei Black, White		
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Marical Evaninar must be neithed at	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2 If Yes, Give Year or Date			1 □Yes 2	X No	Specify:				Specify: Wh	ite	
5-0036	2 hour	bel	15. Decedent's E	ducation		16a. Deced	dent's Usua	Occupa	ation			16b.	Kind of Business/I		
215	hin 7% e. an "na Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4	or 5+)	(Give life. L	kind of wor DO NOT us	done d retired	luring most)	of workin	g				
2121	filed wit Hygien ther the	S		2_		Homem	aker_					1	n Home		
Maryland	be file	Be	17. Father's Name (First, Middle, Las	•							(First, Middle	, Maide	en Surname)		
ž	id 2 should be fil Ith and Mental H 2 7 is marked ot traumatic ever	ပ္	Broadus Rupert			19h Mailir	na Addraes	(Street s			lorgan	ner City	or Town, State, Z	in Cade)	
<u>≅</u>	and 2 s ealth an n 27 is i		Tom R. Allen /				•	,					Maryland		
Ē,	- I i i i		20a. Method of Disposition		CO.	ace of Dispo	sition (Nam	e of			ate		Location - City or		
Baltimore,	permit. Pages: Department of I Important: If ite any Injury or o		1 X Burial 2 ☐ Cremation 3 D 4 ☐ Donation 5 ☐ Other (Spec		^{ate} Fair	fax rial Pa		ici piaci	ر ا		2011	Fai	rfax, Vi	rginia	
alti	rmit. spartn porta y Inju		21. Signature of Funeral Service Lice	nsee		D =	2. Name and	Addres	s of Facility	v		/ Ro	ckville In		
8	8 9 E 8 8		1 Cory Ka		M0159	30	0 West	Mont	gomery	Ave.	Rockvi	11e,	Maryland	20850	
			23a. Part 1. End the disease, or cor shock, or heart failure. List only	nplications that cau	used the death. th line.	Do not ent	er the mode	of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Betw Onset and D	ween
4	Physician		Immediate Cause (Final disease or condition resulting in death)		imer's	ORDER DESCRIPTION OF THE PROPERTY OF THE PROPE	tia							2 Yea	
1	/Medical Examiner		rooding in doubly	Due to (or	r as a conseque	ence of):									
		ē.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or	r as a conseque	ence of):									
A.	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events												
MF.	ate be executed hysician and he burial-transit		resulting in death) Last	CDue to (or	r as a conseque	ence of):	-					-			
8760,	a ===	lical	•	d									-		
9	Attending Physician; The law requires that the death certifica refeath. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE:	23c. If yes, outco	ome of pregnan	CV	7.7								
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 🗌 Live bir	th 2 ☐ Fetal on that time of de	death 3	Ectopic pr		/				23d. Date of del Month		/e ar
P.O.	that the ded by the detached	ysi	1 □ Yes 2 ☒ No 9 □ Unknown	9 Unknov		u 0 L	_ Calor (Sp.	JOIN Y)							
	res that signed to be deta	by PI	Part II. Other significant conditions	contributing to dea	th but not result	ting in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco	o use contribute to	the cause of de	eath?
ğ	w require been sig should b										1 🗆	Yes	2X No 3□ Pr	obably 4 □ U	Jnknown
ဝ၁	law re as be 2 sho	plet									24a. Was		24b. Were au	topsy findings a	available ause of
- -	The sate h	Completed									perf 1 □ Yes	ormed?	death?	2 🗆 No	
Vita	ysician; The I is certificate ha director, page	Be	25. Was case referred to medical examiner?	Heavital				Oth			(Check only			Assis	
Division of Vital Records,	Physical direction	은	1 ☐ Yes 2 📉 No 27. Manner of Death		patient 2 E	R/Outpatier 28b. Time of		A Dine	^{er:} 4 □ Nu	irsing Hon	ne 5 Res	bowin	6 M Other (Specially occurred	city) Livi	ng
on	ttending Ph Jeath. tor: After th the funeral	ertification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,	, Day, Year)	Injury	М	3c. Injun Work 1 □ ¹	ໃ?ີ່ Yes 2 🔲 I		.ou. Describe	11047 111	jury occurred		
İSİ	Attendir death.	ifica	3 Suicide 6 Could not 4 Homicide determined	pe 28e. Place of	f Injury - At hon	ne, farm, str	eet, factory,	office		2			and Number or Ru	ıral Route Numl	ber,
Ö	tal or s afte al Dir ed in	Cert	4 Hottlicide	building	g, etc.*(<i>Specity)</i>						City or To	iwii, Sie	a(e)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	edical		Physician: To the barniner: On the bas and manne	sis of examinati)
	Vith Vith Com	Σ	29b. Signature and title of certifier		~~		29c		e number				Date signed (Monti		
			· Hon	20	ヘリゾ			D44	157			Jan	nuary 6,	2011	
	8		30. Name and address of person who		,	, , , , .	,	n '		- 34	1	, n	00857		
	Sta	te	Ira Berger, M.D. 31. Date fled (Month, Day, Year)		Seven Logistrar's Signatu		coad,	KOC	KVILL	e, Ma	iryiano	1 4	20854		
	Registi		JAN 1 1 2011	Beneva											
	MIL 47 Day 4/0	001			1-17	AND THE PERSON NAMED IN									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 3, 2011 Year Physician/ Robert Vincent Arbuthnot 11:15 A_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Manor Care Bethesda Bethesda Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 579-20-9253 Director 87 January 2 Washington. Usual Residence of Decedent 10a. State District 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No Washington of Columbia 10f. Zip Code 10g. Citizen of What Country? Apt. L-9 Funeral 20020 United States 2652 Martin Luther King Avenue, S.E. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 🛮 Never Married 2 🗆 Married ş 1 ☐ Yes If Yes, Give 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates giene. er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other than injury or other traumatic event, the Auto Mechanic Automotive Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Arbuthnot Mary Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Daugherty / Niece Clover Drive Georgetown, Delaware 19947 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery January 7, 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Bethesda, Maryland 2011 4 Donation 5 Other (Specify) Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 of Funeral Service MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ YOKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a nonsequence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 s performed: 21No 2- No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending work' 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 00054566 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) unisha Bhogaville 9801 Googia ANNW #117 Silverspring MD2090 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 10, Robert James Boyle 2011 10:47 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 6087 Moongong Court Howard Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Hours Oct 18. 74 1936 208-28-7608 Pennsylvania Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6087 Moongong Court 21045 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainmatic mental end in the control of the contr life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) High School 5+ Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Bovle Doris Mackey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4717 Dolphin Cay #A202 Saint Petersburg, FL 33711 Patricia M. Boyle, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. 01/11/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Pemation Society Of Maryland, Inc. 39 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Prospare Ph sician/ + Lung Cancer à disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed to the second 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page rmed? death? certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2X No Other: |요 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Director; After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred Certificate: 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ht, cranp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste '32. Registrar's Signature State Registrar park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G911 1/11/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 11:30' AM 201 BURTON 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE UNION MEMORIAL HOSPITAL 5. Social Security Number 8. Date of Birth (Month, Day, Ye JULY 10, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours Year, 1 □ M 2**X** Director MD <u>212-30-8342</u> Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 4101 BARRINGTON RD. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in the and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) COMPUTER OPERATOR TECHNOLOGY permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JEANETTE NIXON GEORGE W. RODGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD NANNETTE PATTERSON/DAUGHTER 3700 GRANTLEY RD. 21215 20a. Method of Disposition 20b. Place of Disposition (Name of control of the c 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARBUTUS MEMORIAL PK. 1-15-2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1701-31 LAURENS STREET BALTO., MD JAMES A. MORTON & SONS F.H., INC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onsar and Death Ph sician/ Cardio Jenic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiamyopail Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🐼 No Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2. No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title Maryam 29c. License number Keshton Keshtkar Jahromli AT2438946 01/09/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryam Keshtkar Talmomi parkway, Baltimore, MD, 21218 Univ. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fn g911 1-19-11 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 05CH Month 2 0 1 2046 M 2 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ا، وا olum بلح qx benera 0491 004 If Under 1 Year | If Under 24 Hrs. Security Number Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 W Months Days Hours Min Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Tes 2 No mbi 10e. Street and Numbe 10f. Zip Code 23a or 3 10g. Citizen of What Country? 21044 items 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 100 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: 3 ₩idowed 4 Divorced 1ack Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Helle 21. Signature of Funeral Service License 22. Name and Addre 207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. uch as cardiacor respiratory arrest. Approximate Interval Between tion Immediate Cause (Final Onset and Death Physician/ Myoca. b disease or condition resulting in death) Medical Due to (o as a consequence of): Examiner Teus 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical hem i Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 Unknown Pregnant at time of death been signed by the should be detached a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural iniury s after dec. al Director: After 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one Signature 29c. License number 29b 29d. Date signed (Month. Dav. Year) 00 09 94 2011 30. Name and eted cause of death (Item 23a) (Type, Print) EDAZAN 044 75 5 5 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month UURY Physician/ Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** GNES TOS PITA SALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 №M 2 🗆 F Country) Director MD Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Nes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 2120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Blac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) onstruction Em Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl . Page 1 : cemetery, crematory or other place) Surial 2 Cremation 3 Removal from State Home 4 Donation 5 Other (Specif Signature of Frineral Service 22. Name and Address of Facility tome Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Artenoselentie disease or condition Due to (or as a consequence of): Medical resulting in death) **Examiner** Sequentially list conditions, Due to for as a nonsequence of: cause. Enter Underlying Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 \square Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Fractioner: To the best of my knowledge 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berseson 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month⁴ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3518 Overview Road Baltimore NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. (Month, 214-54-6323 Director 61 Usual Residence of Decedent show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 3518 Overview Road 21215 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force 2 Black, White, etcAfrican 1 Never Married 2 X Married be filed within 72 hours after ☐ Yes 2x☐ No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: American Completed traumatic event, the Medical 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Villa Nova 12th Grade Generic Nursing Asst. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Bennett Matolda Parker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4248 Huntshire Road Randallstown, 21133 Keisha Brown-Daughter ΜD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King 01 - 17 - 11Mem. Pk. Randallstown, 21. Signature of Funeral Service Lice see Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a connequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of, Exam Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 687 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 3 Ctopic pregnancy
5 Other (specify) Pregnant at time of death signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 X No 2 X No Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifical et dilled in by the funeral director, it Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Barbara 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 1 Yes 2 No 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1: Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasts of examination arrows investigation, in this opening the past of examiner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linden Av Balt Ma 2/20 31. Date filed (Month, Pay, State Registrar DHMH 17 Rev 7/2009

ORIGINAL

@5:14

11/20/1

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G911, 1/20/2011, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January CECELIA MARIE BROOKS 2011 0400 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Burnie Anne Arundel Glen Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months Days Hours 02 08 Director 218 28 0544 932 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 212 Sillery Bay Rd. 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank I. Hajek Cecelia M. Puncochar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 540 Donna Lenker - daughter Bay Pointe Dr. Montross, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🔲 Removal from State Bayview Crematory 1/10/2011 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home PA 169 Riviera Drive Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Anten COCONARY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year 4 Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 8 B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 **N**0 မ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of Natural 5 Pending injury in 24 hours after deam.
The Funeral Director: Aff 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2011 mara 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAltmore Washington Mn ANC 14 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2011 Registrar

31. Date filed (Month, Day, Year) State Registrar

Moujerie

Margarita Korell MD.

nel 30. Name and a dress of person who completed cause of death (Item 23a)

> Registrar's Signature **DRIGINAL**

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

January 9, 2011

OC 1

O.C.M.E

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day (Month Physician/ BAIRD Year 1900 PM HAROLD 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY HOSPITAL SHADY GROVE ADVENTIST ROCKVILLE If Under 1 Year If Under 24 Hrs. . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dct 9, Day Year) 6 1 X M 2 🗆 F Months Days Hours Min. **Director** 216-68-1438 54 Usual Residence of Decedent 28a-f show aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Montgomery Germantown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12904 Church Hill Ridge Circle Funeral 20874 USA 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? unk
1 ☐ Yes 2 ☐ No Black, White, etc. 1 \square Never Married 2 \square Married "natural", or þ 21215-0036 If Yes, Give Year or Dates black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical soce. 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation unk 16b. Kind of Business Industry unk (Give kind of work done during most of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shady Grove Adventist Hospital 9901 Medical Ctr Dr; Rockville, MD 20850 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in State cemetery, crematory or other place, 21. Sign ture of Euneral Serv S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Osuse (Final Physician/ Cardiac minute disease or cor Medical resulting in death) Due to (or as a consequence of) Examiner Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dusito (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed Pneumonia hours and Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Obstructive Pulmonary Disease Division of Vital Records, P.O. Box 68760 the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
 Pregnant at time of death
 Unknown in the past 12 months? Month Day Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CIN. D0062839 January 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Car Dr Rockville, MB JOSD Jennifer Mea 9901 wiston MD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JANUAR Day 6 1000 Physician/ 2011 BROCATO BE NEDICT Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE BON SECOURS HOSPITAZ If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Maryland 1 M 2 □ F 57 217-64-6668 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County Director 1 🗆 Yes 2 🔀 No MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 21228 USA 239 Gralan Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes Give White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 lith and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Be 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) ပ Delores H. Busch Vincent A. Brocato Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau once. Catonsville, Maryland 21228 239 Gralan Road <u>Vincent A. Brocato Sr</u> Method of Disposition

| Disposition | Compared to the place of Disposition | Compared to the place of Disposition | Compared to the place of Disposition | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the place | Compared to the pl 20c. Location - City or Town, State Baltimore, Maryland 1/11/11 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee Baltimore, Maryland 21229 3620 Wilkens Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYSTEM ORGAN FAILURE MULTIPLE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** DRUBABLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 0 INFECTION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an RENAL FAILURE autopsy death? ACIDOSIC META BOUR 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 1 De Natural 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident
Suicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie JANVARY 07 address of person who completed cause of death (Item 23a) (Type, Print) 21201 BACTIMORE MO 22 SOUTH GREENE ST 32. Registrar's Signature ate fired (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Mary Edna January 2011 7:55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1723 Springhouse Court Frederick Frederick Social Security Number 8. Date of Birth . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral (Month, Day, Ye Sept 13, 1 □ M 2 🏖 F Months Days Hours Director 272-38-9239 67 Ohio Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1723 Springhouse Court 21702 United States or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian injury or other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Health Aide Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ritchie Herve Alvin Marigole White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 Terri Brubaker/daughter 1723 Springhouse Court Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/11/2011 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Licens stinau 23a. Pa. J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ew disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease of Tinjury that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address

160

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 1:00 PM January Christine Louise Brown Medical 4a. Facility Name (if not institution, give street and number) County of Death **E**xaminer 4b. City, Town, or Location of Death aurel Regional Prince George's Hospital aure Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 18, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Hours ^{Year)} 1925 Country IIIinois 338-20-3784 **Director** 85 Usual Residence of Decedent or 28a-f show De filed within 72 hours after death with the Maryland lental Hygiene.

rked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Prince George's Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3128 Gracefield Road 20904 HS108 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates. 1945-46 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Jene. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nicholas Agoras Theresa Gertrude Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Brown/son 11208 Hickory Grove Court Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/11/2011 Woodbine, Maryland . Sign Qure of Funeral Service Lice Going Home Cremation Service P.O. Box 784 stinau 24 homas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Pleural Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑.No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Renal Insufficiency Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Vein Thrombosis performed? ☐ Yes 2 X No 2 X No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation ☐ Acciden 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed, (Month, Day, Year) achelle (Eledion 1)44156

Registrar

State

3110 Grace held

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Beg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day January 4, P M 2011 Margaret Elaine Barr 1:58 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Manor Care - Chevy Chase Montgomery Chevy Chase 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🖾 F 442-16-8331 91 December 26, 1919 Oklahoma Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Chevy Chase Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8700 Jones Mill Road 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □ Yes 2 X No Specify Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 4 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter W. Witt Merle Dupree Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Baker/Friend 11209 Schuylkill Road, North Bethesda, MD 20852 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State January 9, Montgomery 4 ☐ Donation 5 ☐ Other (Specify) Drium, Inc. 2011 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Chevy Chase, In 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Crematoriúm, Inc. 21. Signature of Juneral Service HOUN M01530 7557 Wisconsin Avenue, Bethesda, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrythmia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Dav 5 ☐ Other (specify) 1 ☐ Yes 2 📉 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Urinary Tract Infection 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Box 68760, P.O. Division of Vital Records,

Examiner Examine burial-transi law requires that the death certificate be execute and attending physician for use as the buria Physician/Medical signed by the a d be detached for 2 Atter this certificate has been si funeral director, page 2 should b Completed Be Certification: To Hospital or Attending death. 24 hours after death Funeral Director: filled in by the Medical within 2

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

þ

Completed

Be ပ

d other than "natural", or items 23a or 28a-f sleevent, the Widdal Examination at the notified

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Event

Physician

/Medical

Baltimore, Maryland 21215-0036

the Maryland

death with

8 State Registrar

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 ☐ Yes 2 ☐XNo 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

D0054566

January 4, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $\stackrel{\bullet}{N}_{\bullet}\stackrel{\bullet}{D}_{\bullet}$ 9801 Georgia Avenue #117, Silver Spring, Maryland 20902

Sunitha Bhogavilli,

31. Date filed (Month, Day, Year) 32. Registrar's Signatu JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UTI For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brown Physician/ Month Year 2011 oward 0757 AM ranklin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster Carrol1 8. Date of Birth Oct 10, 1927 5. Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 XM 2 D F Maryland Director 83 217-20-4907 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 Yes 2 X No MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15315 Old Hanover Road 21155 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2X No Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor State Highway Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank L. Laura Boslev traumatic Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5716 Emory Road Department of Health Important: If item 27 any injury or other to Dorothy L. Harry Daughter Upperco, MD 21155 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕱 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gard. 1/8/11 Finksburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of) Fibrillahon Htmal To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and Wonic that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No Yes 2 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 406 1 Hnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Matural 5 Pending work 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🗠 🕳 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminin MD 32. Regist

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Jean J. Baginski 12:00 AN January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 01/26/1918 1 🗆 M 2 🛛 F Months Hours Min 204 01 7106 Director 92 Pennsylvania Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shor Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7013 Cresthaven Drive U.S.A. 21061 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 If Yes, Give 1 Yes 2 No Specify: than "natural", 3 X Widowed 4 Divorced Specify: Year or Dates White injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Homemaker Own Home other be filed Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental i ည Paul Barkiewicz Bronislawa Jablonski t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Baginski / Son 7013 Cresthaven Drive Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 🕱 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery Baltimore, Maryland 01/14/2011 Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ DEMENTIA disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year been signed by the a should be detached 1 ☐ Yes ∠ ☑ 9 ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 s autopsy performe death? Yes 2 No 1 Yes 2 No Be filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examine: On the basis of examination an /or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practicines: It is useful my investigation, shall continue at the time. Late and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of 29c. License number 29d Date signed (Month, Day, Year) 102 M 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) ERNESTINE WRIGHT. 2300 DULANEY VALLEY RD. MD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year JAN 1 1 2011

DHMH 17 Rev 7/2009

State

Registrar

JANUARY

32. Registre's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marjorie Maye Bruno 2011 9:35 P. Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1343 Sleepy Hollow Road Severn Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Hours Min. 08/31/1925 211 18 3060 85 Director Yrs. Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Marvland Anne Arundel Baltimore 1 🗋 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 190 W. Meadow Road U.S.A. 21225 Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes : 2 K No 1 ☐ Yes 2 🕱 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Data Processing USF&G Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David L. Bartlebaugh Mary Magdalene Horbath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Calvert / Daughter 201 South Rock Glen Road Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 01/10/2011 4 Donation 5 Other (Specify) Loudon Park Cemetery! 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 nomenous 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 📞 Onset and Death Physician/ disease or condition resulting in death) emontia Monthe Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the a 1 ☐ Yes 2 ﴾
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires V15060 Completed 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 K Other Daughter's 1 Tes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Natural work' n 24 hours after death.

e Funeral Director: At oleted filled in by the fu 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Wilkens

3455

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	•	partment of Hertificate of I		lental Hygie	2011	00260		
	Physici	an	1. Decedent's Name (First, Middle, Last,)				Date of Death Month	Day Year	3. Time of Death		
	/Medi		Catherine	M	. Bol	d		January	10, 2011	3:00 a M		
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Deat	h		
			Long View Nursin				nester		Carro	11		
	Funeral		5. Social Security Number 6. Sec	x 7.Age]M 2.53∤F	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign		
	Director		219-14-166/	Jim Egg.	88 Yr	• •		July 5,	1922	MD		
1215-0036 Within 22 hours after death with the Marvland	2 ×		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits		
	a de la	ŏ	MD Carrol	1	•					1 ☐ Yes 2X No		
	28a-	Director	10e. Street and Number			Westminste	er	. Citizen of What Country?				
	0 2						21150	109.		on y s		
d d	78 27 True	era	4411 Wine Road	12. Was Decedent E	ver in U.S.	3. Was Decedent of H	21158 ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	nican Indian		
		Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, Whit			
9		by	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White		
5-003	a a	ted	15. Decedent's Edu	cation	16a. D	ecedent's Usual Occup- tive kind of work done of	ation	168	o. Kind of Business/			
215		pie	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5-	- //	e. DO NOT use retired	1)					
N 5	G t	Completed	3			Laund	ry Worker		Laundr	У		
land 2	is thygiene. Hygiene. dother than "natural; or itama 23a or 28a-f ahow event, it a Medical Exactor must be notified at	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Mai	den Sumame)			
Z =		10	Nicholas Bold				Marg	aret Scl	nmidt			
ary	and le m		19a, Informant's Name/Relationship (Ty	rpe, Print)	19b. M	ailing Address (Street	and Number or Rur	al Route Number, C	ity or Town, State, 2	Zip Code)		
≥ 5	# 12 E		Richard Bold	Son	84.	Ewing Dri	ve, West	minster,	ID 21158			
more,	of Hear If item r othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	lamoval from State	20b. Place of D cemetery,	sposition (Name of crematory or other place		Date 200	. Location - City or	Town, State		
Ĕ	ant: I		4 □ Donation 5 □ Other (Specify)		Carrol1	Cremation	Ser 1/1	1/11 Н	ampstead,	Maryland		
	Department of Important: If its any injury or of once.		21. Signature of Funeral Service Licens	00 11	1/.	22. Name and Addres	ss of Facility	11824 I	Reisterst	own Road		
n s	10 5 4 9		sopher	The Do	15km	Eline Fune	ral Home		stown, M			
/Me			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.									
	hysician		tmmediate Cause (Final disease or condition									
	/Medical		resulting in death)	Due to (as a	consequence of)			0		F		
-	xaminer	iner	Sequentially list conditions,	arth	inscli	ota VI	rscala	Diren	u	25/4		
7			if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of)					_ /		
D. a	and tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	The	nun	un				2040		
760,5	cien	Ē		Due toxor as a	consequence of):					711		
SK/ CO, C	physicien and the burial-transit	dicai		ina		20				209		
			IF FEMALE:	12a If was suiteeme s	f organization							
Geath certif	attending for use as	ian	in the past 12 months?	in the past 12 months?						ivery Day Year		
	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ime of death	5 Other (specify)						
ב ב	ad by detec	F	Part II. Other significant conditions cor	int II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions								
ecords,	signed b	d by	•	•		1 ☐ Yes	obably 4 Unknown					
	been si should l	Completed						-				
e e	page 2	m jd						24a. Was an autopsy performed	prior to	topsy findings available completion of cause of		
	icate r, pag							1 Yes 2 2		2 No		
VITAL	is certifical director, p	Be	25. Was case referred to medical examiner?	lospital:		044		h Check only one				
OT VITA	this ral dii	5	1 Yes 2 No	1 Unpatier	1		4 Julivursing Ho	me 5 Residence		city)		
	e f	<u>o</u>	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim Inju	y Worl		28d. Describe how	njury occurred			
VISION	death. ctor: A y the fu	Ca	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injur	a. At home form	M 1 1	Yes 2 □No	28f. Location (Stree	t and Number or Br	real Payers Alumbus		
UIVISION i or Attanding	after Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	street, factory, office		City or Town, S	tate)	irai noule ivumber,		
polta	nerai		29a. Certifier 1 Cartifying Phys	sician: To the best of	my knowledge d	eath occurred at the time	ne date and place	and due to the caus	e/s) and manner or	stated		
HO	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	(Check only 2 Madical Examination)	nar: On the basis of and manner stat	examination and/o	r investigation, in my op	pinion, death occur	red at the time, date	and place, and due	to the cause(s)		
o E	ompl	Me	29b. Signature and title of certifier		1	29c. License	e number	29d.	Pate signed (Monti	h, Day, Year)		
\	,,,,		John WIN	1. 111.	L M	1 77	TYY	2 11	10/20	11		
	F	ŀ	30. Name and address of person who co	impleted cause of de	th (Item 23a) (Ty	pe. Print)	- 111) ''	10/20	//		
)		John W. M.	161.4	m m	C88 P	cele RI	Westma	niba u	11		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	's Signature	40010	7611	V /	14 001	12/2/2		
	Registr	ar	JAN 1 1 2011 A	me 18.	back							
DHMH	17 Rev 1/20	001	K- 41		1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month appron Рм 20111:51 ona January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Month, Day, Y 1 XM 2 □ F Months Days Hours Min. Director 579-42-6719 75 District of Columbia Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits or 28a-f st notified Anne Arundel 1 🗌 Yes 2 💢 No MD Gambrills 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? be ms 23a o Funeral 2487 Red Fall Court 21054 ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: "natural", Specify. Completed 3 Widowed 4 Divorced Year or Dates White Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis Chapman Nellie Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Shirley M. Chapman, wife 2487 Red Fall Court Gambrills, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date o <u>=</u> 6 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Metro Crematory, Inc. 01/10/11 Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of MD, Inc. George MacNabb 299 Frederick Road Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Day Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Yes 1 L Yes 2 L 9 Dunknown 9 Unknown l signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ known 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an hast autopsy performe certificate 2 1 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this . Manner of D ≠ti 1 Natural 28b. Time of 28a. Date of injury Certificate: 28c. Injury at (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the by is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse P only one To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a signed (Month, Day, Year) 9/20k1 ted cause of death (Item 23a) (Type, Print) ddress of person who comple 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenneth Carmich		State of Maryland / Departme 1- For State Certifica				201	1 00263
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Middle,Last) Kenneth Carmichael			2. Date of Dea Month January 5	Day Year	3. Time of Death 1925 hrs
)		4a. Facility Name (if not institution, give street and number) 710 Buckingham Circle	4	b. City, Town, or Location of Deat Salisbury		4c. County of E Wicomico	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Min	n.	th(MM/DD/YYYY) s	B. Birthplace (State or or oreign Country) Maryland
land f show any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 10aryland Wicomico Salish					10d. Inside City Limits 1 Yes 2 No
r death with the Maryland or items 23a or 28a-f show must be notified at once.		10e. Street and Number 710 Buckingham Circle		10f. Zip Code 21804	1	0g. Citizen of What USA	Country?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Maral Hygenia at the Maryland was triem 23 in marked other than "nastural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once	by Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	If Ye	Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto Yes 2 X No specify:	o Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc. Black
md 21215-0036 and 2 should be filed within 72 hours after ealth and Mental Hygiens feet 71 is marked other than "natural", traumatic event, the Medical Examiner	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)	ring mo	's Usual Occupation (Give kind of st of working life. DO NOT use ret	tired)	Govern	3
AD 21215-0036 2 should be filed within 7 1 and Mental Hygiens 7 is marked other than matic event, the Medica	8	17. Father's Name (First, Middle, Last) Eddie McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. I	Mailing .	1	y Florer	Maiden Surname) NCE Via nber, City or Town, S	State, Zip Code)
Baltimore, MD permit Pages I and 2 shou Department of Health Important: Witem 27 is injury or other traumatic		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of I crematory	Disposit or other	101	el, MD 2 Date -11-2011	20c. Location - Cit	
Balti permit. Departrr Imports injury o		4 Donation 5 Other Specify: Metro 21. Signatur of Funeral Service Licensee Patrik Fleming 22. Part I. Enter the disease, or complications that caused the death. Do not e	22. Na	ame and Address of Facility			ce, Maryland c. yland 21228
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The disease or condition resulting in death)		,		est, shock, or heart	Approximate Interval Between Onset and Death
		Sequentially list conditions, f any, leading to immediate ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b				,	
0, the executed sician and burial - transit	adical Ex	d. X UNPENDED AMENDED 23a,27 per	me g	g913 3-7-11 v t	-		
Box 6876(death certificate to attending phys of for use as the b		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Feta	al death 3 Ectopic pregna	ancy	23d. Date of deli Month	very Day Year
. 월 5월 1	2	Part II. Other significant conditions contributing to death but not resulting in	the un	derlying cause given in Part I.			e to the cause of death? Probably 4 Unknown
Records The law requestate has been page 2 should	nataldillo				24a. Was a autops perform 1 Yes 2	sy prior med? death	
- # . ` # 7		55. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outp. 77. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Times 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			g Home 5 F	Residence 6 00000000000000000000000000000000000	ther; Scene
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certificat	2 Accident Investigation 3 Suicide Could not be determined (Specify) 28e. Place of Injury - At home, farm (Specify)	street,		28f, Location (Story Town, Sta		Rural Route Number, City
To the Hos within 24 h To the Fur completely	מונים	9a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death nee) 2 Medical Examiner: On the basis of examination and/or inversal manner stated.	occurre stigation	ed at the time, date and place, and n, in my opinion, death occurred a	due to the cause t the time, date a	e(s) and manner as s and place, and due to	stated. o the cause(s)
	2	9b. Signature and title of certifier MM My		29c, License number O.C.M.E.		January 6, 201	
2000 PM			900 W	/. Baltimore Street, Baltim		23	
Stat Registra	e ³	1. Date filed (Month, Day Year)	alle	1	OOML		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:55 PM FREDA E. CARL AKA FRIEDA E. CARL January 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Cr Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1 🗆 M 2 🔀 F Month Day Year 8 232 26 7205 Hours Director 82 MD Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits MD 1 Yes 2 No Anne Arundel Glen Burnie 10e, Street and Number ö er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 103 Cedar Drive 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ģ 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Otto Carl Olivia Dora Foxwell Page 1 and 2 should I ment of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Anthony - niece 109 Martha Rd. Glen Burnie, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem Pk 1/11/11 Glen Burnie, 21. Signature of Furriera 21 rvice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ myD disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 pronths?

1 Yes 2 No Month Pregnant at time of death Dav Year No. 1 Urknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Hospita 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No filled in by the Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) m erson who completed cause of death (Item 23a) (Type, Print) 30 31. Date filed (Month, Day, 32. Registrar's Sign State Registrar

EDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 00264 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stella Teresa Calvert 2011 January 15:34 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) May 5, 1918 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 1 F Days Hours Min. Director 214-01-6456 Cou*ntry)* Ma**r**vland Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Co. Bel Air 1 Yes 2X No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1220 Cheshire Lane 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married ğ 1 Yes 2 X No If Yes, Give Year or Dates. 1 ☐ Yes 2 💢 No Specify: "natural", Completed 34 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Meat Wrapper Grocery Store Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jan Soltynski Maryanna Drozd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Judith M. Bona / Daughter 1220 Cheshire Lane Bel Air, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🖰 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/13/2011 Brooklyn Park, MD 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EUMUN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Illijury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): signed by the attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 L Fetal deat Pregnant at time of death in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 2 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 2 1 40 1 🗌 Yes 24 hours after death.

Funeral Director: After this certifications of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? _2 No Certificate: To Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accide 5 Pending Division 1 Tes 2 🛄 No ALVERT Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 2011 192056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Birnbaun 500 Upper Chesapeake Drive Bel Air Maryland 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2011 Registrar X DHMH 17 Rev 7/2009

PSC 9401881

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Year Ben Anderson Craig, Jr. January 12:28 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Hours Min 02/23/1933 Director 212-30-5603 77 Georgia Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 66 W. Kingston Park Lane 21220 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Narried 1951 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify 1954 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ben A. Craig, Sr. Ella May Jeffries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merele Dolores Craig (Wife) 66 W. Kingston Park Lane, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 01/12/2011 Brooklyn Park, Maryland 21. Samulate of Funeral Survice Licensee 22. Name and Address of Facility Bruzdziński Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 any 23a. Part 1 __nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Im diate Cause (Final dinase or condition esulting in death) Stage On et and Death Physician/ Emil Cell Ling Cane Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day Year 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page performed 2 No 1 🗌 Yes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital montrent 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No. Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Cife, com 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jay Ε. Coleman РМ 50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Ye. Nov . 20 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F Hours Country, MD Yrs 196<u>2</u> Director 218-74-7384 48 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ge 1 and 2 should be filed within 72 hours after death with the nt of Health and Mental Hygene.

The file file of 2 is an anaked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be it. Funeral 1419 Darley Ave. 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۾ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Prince George Co. Elementary/Seconday (0-12) ÿrs FireFighter Fire Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emanuel W. Coleman, Sr. Beverly A. Betts Emanuel W. Coleman (Brother) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau 4041 Smiths Landing Ct. Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Mem.Pk. Jan.15,201 Balto, Md. Name and Address of Facility
alvin B. Scruggs Funeral Home 22. Name and Addiese Calvin B. Scruge 1412 F. Preston of ature of Funeral Service Licensee St. Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition resulting in death) ALCOHAL CIRRHOSIS OF THE LIVER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 🗌 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown Completed Were autopsy findings available prior to completion of cause of death? perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29c. License number M SOL NURN 30. Name and address of person who completed cause of death (Item 29a) (type, Print)

Registrar

DHMH 17 Rev 7/2009

State

ERNESTINE WRIGHT,

MD

32. Registrar's Si

2300 DULANEY VALLEY RD.

TIMONIUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #2 Per Phy C911 1/19/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 8:27 Timothy Wayne Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Memorial Hospital Harford Havre de Grace Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 48 212-82-8508 1962 Director Maryland Usual Residence of Decedent 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits "natural", or items 23a or 28a-f Maryland Harford Aberdeen 1 XYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 Funeral 61 Baker St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced . Page 1 and 2 should be filed within 7z nous timent of Health and Mental Hygiene. tant: If item 27 is marked other than "natur ilury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Admitting Clerk Medical 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Clark Ruby Wheelock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Juchniewicz / sister 329 Locust St, Perryville, MD 21903 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Harford Mem Gdns 01/14/2011 Aberdeen 22. Name and Address of Facility
Tarring-Cargo
333 S. Parke Funeral Home, , Aberdeen. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending 1 Natural Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital c Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William John Dr	ınar	1- For State Registrar	Maryland /		tment of ficate of		nd Ment	tal Hygiene	Reg. No.	2011	00268
Physici Medical Exami		Decedent's Name (First, Middle,Last)						2. Date of De Month	Day	Year	3. Time of Death
medical Exami	Hei	William John Drinan January 2, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							1140 hrs		
									nne Arundel		
Funeral		5. Social Security Number 6, Sex	7. Age	(In yrs. last	birthday)	If Under 1 Ye			irth (MM/D	DD/YYYY) 9. Birt Foreig	
Director		014-34-4931 1XM	2F		64 Yrs.	Months Da	ys Hours	Min. March	26,		"Sachuetts
any		Usual Residence of Decedent 10a, State 10b, County		10c City To	own or Location	in .				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
B		Maryland Anne Arun	1	roo. Ony, re							1 Yes 2 X No
faryland 28a-f show at once.	Director	10e. Street and Number	del		Severn	10f. Zip Code			10g. Citiz	en of What Cour	
the Man or 2	Dire	151 Myrtle Aven	ue			2	21144			USA	
r death with the Maryland or items 23a or 28a-f sho must be notified at once,	Funeral	11. Marital Status 12.	Was Decedent E Armed Forces?	ver in U.S.		Decedent of H	ispanic Origi	in? (Specify Yes or N	0~ ′	14. Race - Americ	can Indian, Black,
r death	Fun	1 1	Yes 2	No				Puerto Rican, etc.)	- 1	White, etc.	
rs afte ural", miner	è	Widowed 4 X Divorced If Yes or December 15. December 25 Education (Specify only highly 15. December 25 Page 14. Divorced If Yes or December 25 Page 15.	tes:	leted) 1		Yes 2 X No		ind of work done		Specify: Whit ind of Business/Ir	
72 hou	Completed		college (1-4 or 5-			st of working life			100. 1	ind of business/ii	idustry
036 Athin Athin ar that	E D	12	4		Teleco	mmunica	ations	Engineer	C	ommunica	ations
1215-0036 Id be filed within 72 hours afte fental Hygiene. narked other than "antural" event, the Medical Examine		17. Father's Name (First, Middle, Last)		•			18.Mother's	Name (First, Middle,	Maiden S	Surname)	
2121 uld be fi Mental marked c event,	To Be	William J. Dri: 19a. Informant's Name/Relationship (Type, F		1	19h Mailing	Address (Stra	Ethe	1 Virgini per or Rural Route Nur			Zin Codo)
AD 2 sho 27 is mati		Susan Drinan-Bowes	,	er				e, Eldridg			Zip Code)
G, P and I and Health		20a. Method of Disposition		20b. Pla		on (Name of ce	emetery,	Date	20c. L	ocation - City or	
MOI Pages ent of int: L		1 Burial 2 X Cremation 3 Re 4 Donation 5 Other Specify:	moval from Stat	~	The state of the s	atory,	Inc	Jan. 5,20	ıı Ba	ltimore,	Maryland
Baltimore, permit. Pages 1 and Department of Heal Important: If iten injury or other tra		21. Signature of Funeral Service Licensee	M		22. Na	me and Addres	s of Facility	Stallings	Fun	eral Hon	ne, PA
		Misshel Stal	len	1)	31	11 Mour	ntain 1	Rd., Pasad	ena.	MD 2112	22
Physician /Medical		23a Part I. Enter the disease, or complication failure. List only one cause on each line	e. (,	o not enter the	mode of dying	i, such as cai	rdiac or respiratory arr	rest, shoc	k, or heart	Approximate Interval Between Onset and
Examiner			hot Wound of (or as a consequence)			_					Death
		Sequentially list conditions, b									
	Examiner	cause. Enter Underlying Cause	(or as a conseq	juence of):							
it d	хап	Disease of illustrational initiated	(or as a conseq	uence of):							
executed an and al - transi	ig E	d									
60, to be executed ysician and burial - transit	ledical		NDED								
Box 6876 e death certificate the attending phy ed for use as the b	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome Live birth	of pregnan		I death 3	Ectopic p	oregnancy		Date of delivery fonth Da	ay Year
OX 6	sici	1 You 3 No 9 Hakasus 4	Pregnant at ti	me of death	5 Othe	r (Specify)					
D. B.	Phy		Unknown buting to death t	out not resul	Iting in the unc	derlying cause	given in Part	I. 23e. Did to	obacco us	se contribute to the	ne cause of death?
rds, P.O.	þ					,	g.,		_		ably 4 Unknown
ords, w requir	Completed							24a. Was			ppsy findings available
eco ne law te has ige 2 sl	gmc	<u> </u>						autop perfor 1 ✔ Yes	rmed?	death?	mpletion of cause of
tal Rec	0	25. Was case referred to medical				26.Place	e of Death (C	Check only one)	Z INO	1 🗸 Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	9	examiner? 1 ✓ Yes 2 No	i: 1 Inpatient	2 ER	/Outpatient	3 DOA	Other ₄ I	Nursing Home 5	Residenc	ce 6 🗸 Other:	Scene
Ing Pl		1 Natural	a. Date of Injury (Month, Day, Yea an 2, 2011	28 r)	b. Time of Inju		ry at Work?	28d. Describe I Subject sho		occurred /	
SiOP Attence death death sector:	catio	2 Accident Investigation					Yes 2 ✓ N	10			
Division or At ours after defeat Direct filled in by	Certification	Suicide Could not be	Be. Place of Injur B <i>pecify)</i> S ing l			factory, office t	building, etc.	or Town, S 151 Myrtle Av	tate)		al Route Number, City
Hospin 24 hour Funer rely fill		4 Homicide 29a. Certifier 1 Certifying Physician: To				d at the time. da	ate and place				1
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.		one) 2 Medical Examiner: On the									
H % H 2	ž	29b. Signature and title of certifier				29c. Licens	se number		29d, Da	ate signed (Mont	h, Day, Year)
		D-MUL-	*			O.C.I	M.E.		Janua	ary 3, 2011	
iD		 Name and address of person who completed Donna M. Vincenti, MD Assis 				/ Raltimore	Strock D	Saltimore, MD 21	223		
1	ate	31. Date filed (Month, Day, Year)	32. Registrar's			. Dailiinore	oueet, B	varumore, MD 21.			
Regist		JAN 0 7 2011 Beau	4	Mar	Kel						
DHMH 17 Rev 1/20	001	DOME		C	RIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00269 Certificate of Death Reg. No.-. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stanley Francis Dobrzycki Jr. 11:50 A^M 2011 Medical JANUARY 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Min. March 6. 1964 Months Hours 212-58-1874 Marviand 46 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified ** once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Baltimore Cockeysville 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 M Windy Falls Way 21030 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 XX No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) food handler restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Francis Dobrzycki Sr. Agnes Constance Algier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley F. Dobrzycki Sr./father 202 Cherry Lane Pearisburg, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory Jan. 11,201 Baltimore, Maryland Signature of Funeral Service Licenses John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition SEPTIC SHOCK Medical resulting in death) Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a constituence of Due to (or as a consequence of) resulting in death) Last attending physician a for use as the bunal-Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown END STAGE LIVER DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CLOSTRIDIUM DIFFICILE COLITIS autopsy performed? Yes 2 X No 2X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ျ in 24 hours after death.

he Funeral Director: After this of the funeral director and the funeral director. 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural Accident injury 5 Pending work?
1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

D

ALEXET MALININ

JAN 11

31. Date filed (Month, Day, Year)

D0069989

7601 OSLER DRIVE TOWSON, MARYLAND 21204

1.9.11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Dodd 3:55 A M 2011 Bowers Rosemary Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville National Lutheran Home 9. Birthplace (State or Foreign If Under 1 Year I If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 5. Social Security Number Funeral (Month, Day, Year) 05/01/1923 Days Country) 1 □ M 2 🛣 F Months Min SC 87 213-48-4752 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a State 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. If Health and Mental Hyglene titem 23s or 28a-f shootien 27 is marked ther than "natural", or items 23s or 28a-f shootien 27 is marked event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Rockville MD Montgomery 10a. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 20850 U.S.A. Unit #2 9821 Veirs Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married Completed by within 72 hours after 1 Yes 2XXNo Specify: Specify: White 3 K Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Social Worker Anne Arundel County 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Martha Rosalyn Hipp Andrew Jackson Bowers, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vienna, Virginia 22181 Mr. Roy Jacskon Dodd / son 2743 Oakton Park Court, or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/12/2011 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility 1 2nd Ave, SW Singleton Funeral & Cremation Services, P.A. 101357 ar Part 1. Sease, or complications that caused the death. Do not enter the mode of during, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a a function Approximate 23a Part 1. Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Medical (or as a consequence of Due 1 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Directo for as a consecuence of a Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical certificate be IF FEMALE: s, outcome of pregnancy Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Tyes 2 🖳 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 40 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 27. Manner of Death injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cape e(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 28

State Registrar 31. Date filed (Month, Day, Year)

1 1 2011

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Chales Karesh 9701 Veirs Drive Rockville Maryland 20850-3462

32. Regirtrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Karen Patricia Davis 2011 Jan. 9 3:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Months Days 1 M 2 X F Min. (Month, Day Hours Country) Michigan Director 366-50-2537 July Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28af sho wither traumatic event, the Madical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 🗆 Yes 2 🖵 No Cockeysville 10e Street and Number "natural", or items 23a o 10g. Citizen of What Country? Funeral 10514 Pot Spring Rd. 21030 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Florist Floral Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman Carl Michelson Caroline Hilda Franz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aimee Anton/daughter Hemlock Ct., Cockeysville, MD 21030 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important, If ite
any injury or ot 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 1/14/11 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
Timonium, MD 21093 Signature of Fineral Service Licensee Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Na disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of burial-transit Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Month signed by the at d be detached for Year 2 NO 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 110 ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural iniury in 24 hours are:

The Funeral Director: Aff

The funeral filled in by t work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier within 24 hor To the Fune completed fi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and litle of certif 29c. License number 29d. Date signed (Month, Day, Year) 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 3:15 P M Decker 2011Marta Kay January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2522 Hanson Road Edgewood Harford If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth Apr. 3, 1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F West Virginia **Director** 64 232-80-8467 Usual Residence of Decedent 23a or 28a-f show 10b. County Department of Health and Mental Hygiene. Important; or items 23a or 28a-f shoy important: If item 27 is marked other than "natural", or items 23a or 28a-f shoy injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Edgewood Maryland Harford 1 Yes 2 Nio 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21040 2522 Hanson Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: f Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Lochart Gillian Henry Hunter George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2522 Hanson Road, Edgewood, Maryland 21040 19a. Informant's Name/Relationship (Type, Print) James L. Decker / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Re from State Baltimore, Maryland Holly Hill Memorial Gdn 1-13-11 Donation 🎝 🔲 Other (Specify) 21. Sig ature of Fun vice 27 Name and Address of Facility 1317 Cokesbury 1 Home, P.A. Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death endo Physician/ tac disease or condition resulting in death) eal Medical as a consequence of Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending p for use as 1 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Dav Year Pregnant at time of death Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed t should be det 23e. Did tobacco use contribute to the cause of death? Be Completed by No 3 Probably 4 Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident 2 Accider
3 Suicide Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D548 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 S. Atwood Road, Suite 200, Bel Air, MD 21014 Ashkan Bahrani MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Danko Anthony January 7 4:20 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5523 Wicomico Drive New Market Frederick If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Year) Country Director 186-24-6403 76 1934 Pennsylvania Usual Residence of Decedent or 28a-f shov 10a State 10b. County 10c. City. Town or Location traumatic event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 Tes 2 No Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a 5523 Wicomico Drive United States 21774 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other. ğ 1 Never Married 2 Married 1

Yes 2 □ No 1 ☐ Yes 2X No Specify: If Yes, Give 3 - Widowed 4 - Divorced Specify: Completed Year or Dates. 1955-57 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Building Engineer Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Steve Danko Elizabeth Pifko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Danko/wife <u>5523 Wicomico Drive New Market, Maryland 21774</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 1/13/2011 F**i**nal Woodbine, Maryland Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 ature of Funeral Service Lice M00957 23a. Pa. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to ause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consultence of Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Affect in by the fur Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital 24 hours Medical 29a. Certifier within 24 hound To the Fune completed file Psertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Es Kunder,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Frederick, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5^{Day} 2011 Physician/ Τ. Elizabeth January 6, Dougherty 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home and Village Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, August 22 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🗓 F Hours 198-16-8528 Director 89 Pennsylvania August Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2X No Prince George's Bowie Maryland ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11804 Parallel Road 20720 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed 3 X Widowed 4 Divorced Specify: Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea gines. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Coll Rose A. Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Ligis / Daughter 11804 Parallel Road Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State January 8, 1
Burial 2
Cremation 3
Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) <u>Bethesda,</u> <u>Maryland</u> Crematorium 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home Bethesda-ChewChase, Inc 7557 Wisconsin Avenue Bethesda, Maryland 20814 They than MO 1360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of Examiner Sequentially list conditions, if any, reaching to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trai resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth Pregnant Unknown in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 4 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 PNO Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No ☐ Accider ☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) a muery6,

Registrar

DHMH 17 Rev 7/2009

State

9

26033 Ridge Road, Damascus, Maryland

20872-1848

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karesh

Charles W.

31. Date filed (Month, Day, Year)

JAN 1 1 201

M.D.

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1622M **JAMES** DUNHAM 900 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospite SOMAIX ty N/A Juny 11 6. Sex 1 M 2 □ F If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Hours Min. SOUTH CAROLINA 90 Yrs Director 249-16-0984 Usual Residence of Decedent 10b. County death with the Maryland the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3000 TOWANNA AVENUE APT 108 U.S.A. or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 XX Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RETRIERS EDMUND TIRE CO 12th grade traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve မှ GEORGE DUNHAM VERGIE McKEMIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanora E. Dunham/Wife 3000 Towanna Ave., Apt 108, Baltimore, Md., 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL 01-15-2011 BALTIMORE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** so de num Maxe if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dread 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical Pcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SUKGEN 828529325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215. JAMSHED SINATE HOSPITAL BALTIMENE 20004

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Mon

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Januar 0440 AM Braeden Farkas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOPKINS n/a Hospita 8. Date of Birth January 7,2011 Social Security Num If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Mary land Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medica Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Rosedale 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Alton Ct. 21237 within 72 hours after death with United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗓 No Completed by 1 X Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) n/a n/a n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jeremy Matthew Farkas Carly Michelle Bernier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremy M. Farkas/father 8 Alton Ct. Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem GardJan. 10,2011 4 Donation 5 Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John O. Mitchell IV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 PJA Timonium, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death extreme prematurit Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Year Pregnant at time of death 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 ☐ No certificate | 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) P22.456 1/7/2011

State Registrar 32. Registrar's Signature

600 North Walfe Street Baltimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melissa Russa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 8:40a M 2011 LEONA FREDERICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GILCHRIST HOSPICE CENTER TOWSON Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Days Hours Min. (Month, Day, Ye -12-192 MARYLAND Director 89 213-14-5196 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director must be notified 1 Yes 2 □ No N/ABALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 6825 CAMPFIELD RD 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married ò 21215-0036 Specify: BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 √ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) EXECUTIVE STATE OF NEW YORK Be traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I t. Page 1 and 2 should be fill thent of Health and Mental rtant; If item 27 is marked or jury or other traumatic events. ည MILLICENT KEENE GEORGE ALBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONES (COUSIN) 2517 E. NORTHERN PARKWAY BALTIMORE, MARYLAND 21214 ALLEN F. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it cemetery, crematory or other place) 1 A Burial Crema ion 3 🗌 Removal from State GARRISON FOREST VETERANS 1-14-2011 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Oxfor (Specify) HIBNEL 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Service Licensee JONATHAN. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician PUL COR disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Day Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 000 nospice Certificate: To 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 \square Pending 2 🗆 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical

State Registrar

29a, Certifier (Check

only one) 29b. Signati

3

31. Date filed (Month, Day, 32. Registrar's Signature 1 1 2011

nd address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11-00148 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Troy Goodie, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar^{*} 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ 3. Time of Death Month Day January 5, 2011 Medical Examiner 0604 hrs 10000 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or **Funeral** Min. Foreign Months Director 1 M 2 F Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. mor Directo 10f. Zip Code 10e, Street and Number Chatham 10g. Citizen of What Country Funeral Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. Armed Forces? 1 Never Married 2 Married Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. If item 27 is marked other than ntar 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Majden Surname) Harnes IVOU 0000 anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit. or Town, State, Zip Code) Baltimore, MD Havnes MU 21211 Saltimore nanne 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 1 Surial 2 Cremation crematory or other place 3 Removal from State awk 5 Other Specify Syn Mary of Funeral Service Lice 22. Name and Address of Facility Howell eral Lto. MD Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Sudden Unexplained Death In Infancy Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,2/,28a-t per me g912 2-15-11 vt #10e,perFH,G911,1/11/11,WS X UNPENDED attending physician or use as the burial Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery . Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? certificate ✔ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other 1 Yes After tl funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun unknown, while sleeping in Natural Pending 1 Yes 2XX No fd 1-5-11 fd 5:00am Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 X Could not be determined (Specify) 2459 Westport St. Balto, Md. Townhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

29c. License numbe

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 5, 2011

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

OCME

29b. Signature and title of certifie

Carol Allan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:25 PM **Physician** January 20 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 M 2□ F Months Days 212-46-092 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. Monce. ld 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memoria 201 22. Name and Address of Facility
105eph RYSS Fun
2222 W. North Ave. 21. Signature of Funeral Service Licensee Home uneral Ba Md 23a. Part 1 Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio myo pathu Immediate Cause (Final Physician schemic months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Stage years rencul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine months Hospital or Attending Physician: The law requires that the death certificate be executed vascular physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ trasolant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed valvular Aortic Cliscone 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes After this certification funeral director, I 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1☑Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P24069 lint January 2011

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 1 2011

DHMH 17 Rev 1/2001

illis, Fredovick

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print Hlaing Tint 900 S Codon Ave

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 8:14 AM Grohman 2011 Elizabeth Hope marga Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore City N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🔯 F Months (Month, Day, Year) 2007 Hours Director 3 213-81-1702 Dec. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Dunda1k Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 7848 St. Gregory Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian 12. Last Black, White, etc. þ 1 X Never Married 2 Married Yes 21 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Dependant N/A and 2 should be filed wit Health and Mental Hygie tem 27 is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Christopher J. Grohman Melissa A. Kemberling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Grohman (Father) 7848 St. Gregory Drive Dundalk, Maryland 21222 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tone. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ર્ક Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Mem. Cemetery 1/11/2011 Sykesville, Maryland 21. Signature of Funeral Service ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland eis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebral hernication disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Encephalopathy POXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last State Epileptici The law requires that the death certificate be executed Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year signed by the at d be detached for 1 ☐ Yes 2 Ц 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2 🗌 No ☐ Yes Yes Hospital or Attending Physician: 25. Was case referred to medical l e 26. Place of Death (Check only one) examine? Other: 2 No 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death. Funeral Director. After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert MD D0038127 January ed cause of death (Item 23a) (Type, Print) Name and address of person

DHMH 17 Rev 7/2009

State Registrar SINAI

Kerberg

, MD

2401 West Belvedere Avenue Billinde

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Bernard Frank Gentile 2011 MAMARI 2-55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BELCA IUBR If Under 1 Year | If Under 24 Hrs, 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F Months Days Hours Min Director 212-10-1947 April 1918 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Midical Evant has recitled at 10a. State 10d. Inside City Limits Maryland Director Harford Edgewood 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1918 Hanson Road 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 XNo δ Specify: Specify: Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing Company 8 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental Philip (nmn) Gentile Margaret (nmn) Schoenhoff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ann Gentile / daughter 7018 Tralee Drive, Dublin, OH 43017 permit. Pages 1 and Department of Heall Important: If Item 2 any Injury or other once. Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus: 01-10-11 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner TUIZUZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its later as one of the cause of Examiner Due to ter as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş ubluly alud After this certificate has been si funeral director, page 2 should I Completed 1 Yes 2 No 3 Probably Unknown Denextin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAT ALLA DUBY OF HE (LLS 1) MAC Phail RL bel Air MO 21014 GLS 13 Mac 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2:14 P.M Physician raren anvary 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 219-70-1109 1 🗆 M 2 🗗 F 51 Mar.5,1959 MD Director Usual Residence of Decedent the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò ral", or items 23a o Examiner must be 1400 E. USA Madison St. Apt. 903 21205 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 🗌 Yes 2√ No Maryland 21215-0036 1 ☐ Yes 2√ No Specify þ If Yes. Give Specif Black 3 Widowed 4 Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Security Guard Temp Agency event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be th and Mental F 27 is marked of traumatic ever Leroy Allen Charlotte Adams 욘 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Yancey III, (son) 1112 Andover Rd. Baltimore, Md. 21218 Important: If item 2; any Injury or other Pronce. Health em 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State Trinity Cemetery Jan. 14, 2011 Balto, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Calvin B. Scruggs Funeral Home made Preston St. Balto, Md. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wer **Physician** cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed y physician and as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as IF FEMALE: JSe 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Year ģ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) d by the at detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2**€** No 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural Injury M 1 Yes 2 No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) ö filled 24 hours 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 24 ho

To the Fune

completely f (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6,2011 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State	State	of Maryla		artment of h		and M	ental Hyg	giene	1-100	00283
	Registrar 1. Decedent's Name (First, Middle, Last)						rtificate of Death				Reg. No.		
	Physician/							2. Date of Dear	Day	Year	3. Time of Death		
		Medical Belly Louise Gross					4b. City, Town, or			January			4:45 A M
	Examin	illel , , ,					Rocky		rDeath		4c. County		
	Funeral		Casey House 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		24 Hrs.	8. Date of Birth		1tgon	place (State or Foreign
	Director		214-48-6138	1 □ M 2 🖾 F	64	Yrs.	Months Days	Hours	Min.	May 25	Year) 946	Cour	Maryland
			Usual Residence of Decedent							raciy 25	1740		ratyland
pue	sho d at	ţoţ	10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
Mar	28a-	Director	Maryland Monto	omery		Boyo	ls						1 ☐ Yes 2🔀 No
dt d	a or be n	E D	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?	
h wi	ns 23 must	Funeral	21701 Slidell R	load			208	41			United	l Sta	ites
teac	r iten		11. Marital Status	Armed Fo	edent Ever in U orces?		Vas Decedent of H f Yes, specify Cuba					e - Amerio k, White,	can Indian,
5 5 1	ıl", o	d by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi		1	☐ Yes 2X No	Specify:		,	Specify:		
32.00-612 in 72 hours after	atura cal E	Completed		Year or D	ates.	160 Doos	lent's Usual Occup	ation				AATIT	
3 2	n "n	ηdμ	(Specify only highe	st grade completed		(Give I	rient's Osual Occup kind of work done (O NOT use retired)		of workin	g	16b. Kind of Bu	isiness In	dustry
Z ighi	iene. rrtha the I		Elementary/Seconday (0-12)	College (1-4 or 5+)		shier			1	Hosn	oital	itv
	othe othe	Be	17. Father's Name (First, Middle, L	ast)		, ,,,		18. Mother	r's Name	(First, Middle, N	Maiden Surname		107
Maryland 2 should be filed	fenta rked tic ev	2	Robert He	enry Jev	well			Ha	llie	Lee	Steve	er	
משלק	h and Mental Hyg 7 is marked othe traumatic event,		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address (Street				City or Town, S	tate, Zip (Code)
∑ 5	n 27 er tra		Amy L. Gross/d	laughter		21701	Slidell	Road	Воу	ds, Ma	aryland	2084	.1
ore Tar	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Devial 2 Moremation	2 Demonstration			sition (Name of natory or other plac	e)	Da	ate	20c. Location -	City or To	own, State
baltimore, permit. Page 1 and	ment ant: l ury o		4 Donation 5 Other (S		Otato		ney Crema		1/10	/2011	Woodbir	e, M	aryland
	Depart Import any inj once.		21. Signature of Funeral Service L	censee							70 P O	Boy	784
			Juanta OK	Homas			Name and Address ing Home verly L.					<u>ille</u>	MD 21029
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that nly one cause on e	caused the dea ach line.	th. Do not ente	r the mode of dyin	g, such as ca	ardiac or	respiratory arre	est,		Approximate Interval Between
	ysician/		Immediate Cause (Final disease or condition	Kid	dney Car	ncer							Onset and Death
	Medical xaminer		resulting in death)		(or as a consec								
		er	Sequentially list conditions,										
Ď	sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	(uence of):									
secure.	and I-tran	Еха	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
pe e	physician and s the burial-transit	dical											
cate b	s the			d									
oertific	nding use a	n/N	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn						23d Dat	e of deliv	en/
death c	atte d for	icia	in the past 12 months? 1 ☐ Yes 2 🍱 No	4 Preg	gnant at time of		Ectopic pregnanc Other (specify)	У			Mor		Day Year
the d	by the	Physician/M	9 ☐ Unknown										
that	ned t	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						pacco use contribute to the cause of death?				
dS,	en sig	Completed by	Lung Cancer				1 □ Y€	☐ Yes 2 ☐ No 3 ☐ Probably 4★ Unknown					
IW re	as be 2 sho	ple							24a. Was an autopsy findings a prior to completion of ca		psy findings available		
VICAL RECORDS,	ate hi	, or								autops perforn 1 Yes 2	med? d	eath?	
ia	ortifica ctor, I	Be (25. Was case referred to medical examiner?				26. Pla	ace of Death	(Check c				
VIII hysic	nis ce I dire	2	1 ☐ Yes 2 🙀 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🗆 Nurs	sing Hom	e 5 Reside	ence 6X Othe	r (Specify	Hospice
VISION OF	fter tl inera	ite:	27. Manner of Death 1 Natural	28a. Date (Mon	of injury eth, Day, Year)	28b. Time of injury	28c. Injury work	at	28	3d. Describe ho	w injury occurre	d	
tendi	leath tor: A the fu	iţi	2 Accident Investig	ation			M 1 🗆	Yes 2 N	No				
or At	offer of Direct in by	Certificate;	4 Homicide determi	28e. Place	of Injury - At he ing, etc. (Specif	ome, farm, stre	et, factory, office		28	of. Location (Street and Number or Rural Route Number, City or Town, State)			
pital	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying	Physician: To the b	aget of mustimes:	lodge death -	onered at the time	date and a	200	duo to the	(a) 1 ·		
e Hos	Eted	Medical	(Check 2 ☐ Medical Ex	kaminer: On the bas Nurse Practioner:	sis of examination	n and/or investi	gation, in my opinio	n, death occu	urred at th	ne time, date and	d place, and due	to the car	use(s) and manner stated.
To the	withir To the comp	2	29b. Signature and the of certifier	O C	.5 and Deat Oill	- movieuge, d	29c. License		па ріасе,		gd. Date signed		
			Nakan Miller -					R14320	1		1/5	111	
	5		30. Name and address of person w	/ho completed caus	se of death (Iten	n 23a) (Type, P	rint)				//	/ ! '	
	,_		Deborah Mil		Muncas	ster Mi	ll Road	Rockv:	ille	, Maryl	and 208	55_	
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. R	legistrar's Signa	iture		7200	S. N	***************************************			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Betty J. Gorsuch 10:30 РМ January 6, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Silver Spring Prince George's
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, May 28)

 Months
 Days
 Hours
 Min.
 . Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 579-34-6513 83 Washington, D.C. **Director** 1927 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3126 Gracefield Road #317 20904 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker es 1 and 2 should be filed wi of Health and Mental Hygier fitem 27 Is marked other th 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Collins Hazel B. Keller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Gorsuch/Son 15400 Indianola Drive, Derwood, Maryland 20855 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery crematory or other place)
Cedar Hill 20a. Method of Disposition 20c. Location - City or Town, State January 10, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv 21. Signature of Fuperal Service Licensee Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Efiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 11/27/10 Immediate Cause (Final Intracerebral Hemorrhage hysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Use to for as a consequence off Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No Month Year Day 5 ☐ Other (specify) ned by the a detached for 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records∜ ò cate has been sign page 2 should be Atherosclerotic Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2⊠No 1 ☐ Yes 2 ☐ No 1 □ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ical Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🛚 Natural 1 □Yes 2 □ No 24 hours after death Pruneral Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 January 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Eugenio S. Machado, M.D. 3160 Gracefield Road, Silver Spring, Maryland 20904

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Server S. Sparker

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:33 p^M January 2011 JAMES Ε. GRIFFIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ABERDEEN
If Under 1 Year | If Under 24 Hrs. 327 OAK STREET HARFORD CO 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 ★M 2 ☐ F Yrs. Director 98 9 1912 MARYLAND 217-09-4533 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No Director MARYLAND CECIL CO. PORT DEPOSIT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 452 COKESBURY RD. 21904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXX ves 2 □ No If Yes, Give Year or Dates# 3 / 45 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: BLACK ģ **3**OXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) LABORER A.P.G. 3rd grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H is marked of 2 ALEXANDER GRIFFIN unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depurtment of Health and Importent: If item 27 is m any injury or other traum 327 Oak St., Aberdeen, Md., 21001 Evelyn Griffin Jordan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BERKLEY CEMETERY 01-08-2011 DARLINGTON, MARYLAND 21. Signature of Cheral Service Toepises 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. Moun 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part 1. Even the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brady Cardor
Due p (or as a consequence of): Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Hyemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown N Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ds, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an N autopsy performe Semention 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Daughter's Be 26. Place of Death | Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) ို 1 ☐ Yes 2 ☐ 1/0 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Deceased 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Medical Certification: Hospitel or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospitel or Attend within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide tiperitiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cestifier 29d. Date signed (Month, Day, Year) D56888

State Registrar 31. Date filed (Month, Day, Year)

JAN 10 2011

DHMH 17 Rev 1/2001

to

9

0

South

Jamshid

30. Nam and address of person who com, leted cause of death (Item 23a / ype, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 8:12 2011 len Medical 4a. Facility Name (if not institution, give street and nymber) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HMOre If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct 9 19 Birthplace (State or Foreign Country) Social Security Number 6 Sex L 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2**X**□ F Hours Min Months **Director** 1978 China Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Baltimore Windsor Mill 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Village Pine Court Apartment #3D 21244 China 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian If Yes Give "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file marked ပ De Yu Huang Unknown and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is Wen Song Chen / HUSBAND 105 Village Pine Court Apt #3D, Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc.: 01-10-2011 Baltimore, Maryland 21. Snature of Funeral Service Licensee Patrik Fleming

22. Name and Address of Facility

Cremation Society Of Maryland,

23a. Part 1. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line. Inc Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of signed by the attending physician and abe detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in my children death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Sign

Street Baltmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. t's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0752M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 2702 Wild Holly Road Annapolis 8. Date of Birth (Month, Day, JAN 27 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday, **Funeral** Months **Director** 178-26-2911 78 Pennsvlvania Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Annapolis MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country's Funeral 2702 Wild Holly Road 21403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?

X Yes 2 No
Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White Completed 3 Divorced 4 Divorced Year or Dates.1957-1992 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care <u>Physician</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Wotring Ruth Ε. Thomas Stanley Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, MD 2702 Wild Holly Road Sheila A. Henry, wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If ite any injury or ot cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/08/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line. Phaet an Phaeths Immediate Cause (Final TAT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine or any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ∟ 9 ☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 1 Yes 1 ☐ Yes 2 € 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) death (Item 23a) (Type Print) Name and address of person who completed cause of death (Item LYS DEFENSE HOW ANNAPOLIS, M.DOM

DHMH 17 Rev 7/2009

State Registrar G

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year James Donald Headings 18:26 JANUARY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death Baltimore City Good Samaritan Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth **Funeral** Months Hours (Month, Day, Y 206-30-5753 **Director** 72 Usual Residence of Decedent or 28a-f show s notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore City Baltimore 1X Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 3308 Paine Street 23a 21211 USA items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc. ö þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify. "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working College (1-4 or 5+) 4 years life. DO NOT use retired) Elementary/Seconday (0-12) Personnel Management Manufacturing is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harriet Schmidt William Eugene Headings Department of Health and Meni Important: If item 27 is marke any injury or other traumatic (19a. Informant's Name/Relationship (Type, Print)
Beverly Jane Headings/ WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Sands Drive Annapolis, Maryland 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Jan 11, 2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PHUEMOMIA ASPIRATION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RESPIRATORY TYPE 2 WITH Esquentially list conditions, if any, leading to immediate cause. Enter Underlying COPD- CHRONIC OBSTRUCTIVE PULMONARY DISE and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury CONGESTIVE MEART URE that initiated events resulting in death) Last Due to (or as a consequence of). attending physiclan a for use as the burial-Physician/Medical CARDIOMY Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RIBRILLATION Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation To the Hospital or Atte within 24 hours after de To the Funeral Director completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eal 5000 ANUARY 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BOULEVARD BALTIMORE ZUN E ET SARAI 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MD JAN 1 1 2011 Registrar

DHMH 17 Rev 7/2009

80

7

9

9

0

W

2

t

DIIO

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 Year I Physician/ Day 04 Henderson Harrow F. 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** woodgate Baltimore 8047 Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M 2 🗆 F 68 Months Hours Min (Month Day, Director Usual Residence of Decedent or 28a-f show s notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code ral", or items 23a or Examiner must be n 10g. Citizen of What Country? Funeral 804 21244 USA Was Decedent Ever in U.S 12. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) York Elementary/Seconday (0-12) College (1-4 or 5+) laintenance Be 17. Father's Name (First, Middle, Lgst) 18 Mother's Na ပ Green Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Ny Rural Route Number, City or Town, State, Zip Code) MD 2/268 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other p 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -2011 timure, Signature of Funeral Service Licensee Funeral Services 22. Name and Address of Facility au 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ hemoptysis Massive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner can cer Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to s a consequence of) signed by the attending physician and deed be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 5 Other (specify) Yes g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed page 2 disease 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No Investigation Accident after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examîner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only gae) 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) D69375 2011 January 10, MD

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address

Korgaonkar

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Nikhilesh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death : 30 AM Physician/ Medical 4a-Facility Name (if not institution, give street and number **Examiner** County of Death 3/1/2/10/6 8. Date of Birth If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State of Foreign 1 XM 2 - F Country) Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 101 **Examiner must** 12. Was Decedent Ever in U.S. Armed Forceş? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i Health and Mental I item 27 is marked o Print) 19a. Informant's Name/Relationship (Type, (mother 21244 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) # e 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Cromatory 2011 |4 ☐ Donation 5 ☐ Other (Specify) 21. Dignature of Funeral Service Lic uneral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to or as a consequence if): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and dedecated for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown nee 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as autopsv pad performed Yes 2 this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one examiner? 2 X No Other: 1 🗌 Yeş 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No ☐ Accident Investigation Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29d. Date signed (Month, Day, Year) ath (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

State Registra DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

luas

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

January 10, 2011

29c. License number

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Wynne Hirsch 2011 7:45 PM Jan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Thomas More Nursing & Rehab Hvattsville Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX** (Month, Day, Months Davs Hours Massachusetts Director 169-32-0585 Usual Residence of Decedent show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2XXNo Virginia Fairfax Vienna 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A8407 Berea Court 22180 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 72 hours after 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Specify: Completed White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Assistant Public Schools Be and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Weldon Wynne Eisenhart Kirby Elizabeth Miller 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Michael Stephen Hirsch Vienna, Virginia 22180 8407 Berea Court Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Page 1 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Triangle, Virginia uantico_Nat'l Cem. | 01/12/2011 | permit. 21. Signa ury of Funeral Sarvice Licensee 22. Name and Address of Facility 171 W. Maple Ave. Vienna, VA Money & King Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Betweer ARTENIASCHENOTE Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown a Hinknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed' 210 2 🗆 No Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) 2 🖪 No Hospital: Other: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1	10	13	0	1
1	U		ч	
L.f	U	-	_	1

	Jan .	Ex	amir	er
5PM		Fun Dire	eral ctor	
Martin Huber Orlogizon 2325PM	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f ahow	any injury or other traumatic avent, it a Medical Examinar must be notified at once.	To Be Completed by Funeral Director
	P.O. Box 68760, &	Physic /Med Exami	nached for use as the burial-transit	hysician/Medical Examiner

Physician /Medical

	1 - State Registrar	of Maryland /		tificate of l			Reg. No.	011	00293
ian	Decedent's Name (First, Middle, Last)			1		2. Date of De. Month	Day	Year	3. Time of Death
cal	Martin Jos	-	T	Huber	Jr.	Januar		2011	23:25 ^M
ner	4a. Facility Name (If not institution, give street and n 3907 Fleetwood Avenue	imber)		Over	Location of Death			County of Death	
	5. Social Security Number 6. Sex	7. Age (In yrs. last I	oirthdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			lace (State or Foreign
	Months Days Hours Min. (Month, Day, Year)								yland
	10a. State 10b. County	10c. City, To	wn or Loc	ation		-		10	Od. Inside City Limits
ţċ	Maryland Baltimore		Ove	rlea					1 ☐ Yes 2 🔀 No
l'e	10e. Street and Number		10g. Citizen of What Country?						
a	3907 Fleetwood Avenue		21	206		J	JSA		
Iner	11. Marital Status 12. Was Der Armed F	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - America Black, White, 6				
Completed by Funeral Director	1 X Never Married 2 Married 1 ☐ Yes G 3 ☐ Widowed 4 ☐ Divorced Year or	□Yes 2□Xvo	Specify:	, , , , , , , , , , , , , , , , , , , ,			ite		
eted	15. Decedent's Education (Specify only highest grade completed	16	a. Decede	ent's Usual Occupa	ation during most of work	ing	16b. Kin	d of Business/Ind	lustry
dmo	Elementary/Secondary (0-12) College 12 years	1-4or 5+)		ever Work			N	I/A	
BeC	17. Father's Name (First, Middle, Last)			JVCI WOIN	18. Mother's Name	e (First, Middle,		-	
To B	Martin Joseph Huber Sr.				Virginia	a L. You	well		
	19a. Informant's Name/Relationship (Type, Print)	15	b. Mailing	Address (Street a	and Number or Run	al Route Numbe	er, City or	Town, State, Zip	Code)
	Virginia Huber Moth	ner	3907	Fleetwoo	d Avenue	, Overle	ea, M	Maryland	21206
	20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from	cemei cemei	ery, cremi	ition (Name of atory or other place ITNEY CTE	🕖 Janu			ation - City or To	
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses,	00			uheral H	, 2011 ome Of I		dbine, Ma lk.P.A.	aryland
	enthous Conn	elly	71	10 Solle	rs Point	Road, I	Dunda	lk,MD. 2	21222
	23a. Part1. Enter the disease, of complications that shock, or heart failure. Let only one cause on	caused the death. Do	not ente	r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	rbid Ol	oes,	ity					Onset and Death
	resulting in death) Due to	(or as a consequenc	e of):	1					
-	Sequentially list conditions, b.	(or as a consequenc	N. (D.)						
를	cause. Enter Underlying Cause (Disease or injury	(c) de a consequent	J 01):					- 1	
хаг	that initiated events c.	(or as a consequence	e of):						
edical Examiner	d.								
led									
an/N	23b. Was decedent pregnant	tcome of pregnancy birth 2 Tetal dea	th 3∏E	Ectopic pregnancy			23	3d. Date of delive	ry
Physician/M	1 Yes 2 No	nant at time of death		Other (specify)				Month	Day Year
Phy	a □ Oukuowu					_	-		
Ď	Part II. Other significant conditions contributing to	-	in the und	dertying cause give	n in Part I.				e cause of death?
eted	Hypertension	1				1 1	/es 2□		
Completed by						24a. Was autop	SV	prior to con	sy findings available appletion of cause of
S						1 Yes	med? 2 No	death? 1 ☐ Yes	2/X No
) Be	25. Was case referred to medical examiner? 1 Vas 2 No Hospital:		-	Othe	26. Place of Death	1			
٦ ۲	1 XYes 2 No 1 □ 27. Manner of Death 28a. Date	Inpatient 2 ER/C	Outpatient Time of	3LI DUA	4 ☐ Nursing Ho	me 5 Resid		Other (Specify	"
atlor	Natural 5 Pending (Mor	th, Day Year)	Injury	28c. Injury Work	? ? res 2 □ No		,,	000000	
Iffe	3 Suicide 6 Could not be	of Injury - At home,	farm, stree	et, factory, office		28f. Location (S	Street and	Number or Rural	Route Number,
Cert	# [] Hollingide Dulic	ing, etc. (Specify)				City or Ton	m, State)		
Medical Certification:	29a. Certifier 1 Certifying Physician: To the (Check only one) 1 Medical Examiner: On the 1 and mar	best of my knowledgasis of examination a	ge, death o ind/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occurr	and due to the ded at the time, d	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
₹	29b. Signature and title of certifier			29c. License	number		29d. Daţe	signed (Month, L	Day, Year)
	I bloom M)	eputy		D18	667		011	10/201	O
2	Philip Mil tello Mo	se of eath (Item 23a			herville	Md 2	100	73	
te	31. Date filed (Month, Day, Year) 32.1	legistrar's Signature			- VM	+			
ar	JAN 1 1 2011 Server	A par	les 1	_					
001	4 Vict								

DHMH 17 Rev 1/2001

0

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HUMPHREY 14:24 M JAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMURE n OF UNIVERSITY MARYLAND MEDICAL Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth If Under Year Funeral **1X**XM 2 □ F Month Day Year) 7 29 / 1927 Director 217-22-1844 MD 83 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7424 Watersville Rd 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1945-47 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Pressman Baltimore Business Forms Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Humphrey, Sr. Elva Lee Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Humphrey/Wife 7424 Watersville Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lake View Mem. Park 1/8/2011 Sykesville, MD 21. Signature of Funeral Service Licensee Burrier due facilifuneral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Imme lat Cause disea or condition resulting in death) Cause (Final condition Onset and Death Physician, Bilatera Pontine Medical Examiner 40 hrs Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Tes completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital: Other: ٩ 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours a To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a JANUARY, 4+6, 2011

8t \

DHMH 17 Rev 7/2009

Registrar

Baltimore

MD 21201

16 S. Evtaw St. 3rd Floor

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATPUTE

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760 within 24 hours a

DHMH 17 Rev 1/2001

State Registra

DD061670

MEDICAL CENTER DRIVE

M.D.

9901

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OVSZKY

32. Regist

VESZEL

EDINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Mary Registrar	•	tificate of Dea		aı mygler Reg. l	2011	00296
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) WANDA WITHERILL		HIGBEE	Mo	ate of Death onth	Day Year 5 201 1	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number) NORTHWEST LOSPITAL		4b. City, Town, or Loc	ation of Death	-	4c. County of Dea	
74-4 1	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. 8. Da	te of Birth	BALTIN	thplace (State or Foreign
	Director		155-01-6697				onth, Day, Yea	916	nuntry) NY
/land	f show ed at	tor		c. City, Town or Loc	ation				10d. Inside City Limits
Man	28a- notifie	Director	MD Baltimore	Owin	gs Mills				1 ☐ Yes 2 💢 No
th the	3a or t be r	ral 🗅	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
ath w	ems 2	Funeral	12. Marital Status 12. Was Decedent Ever in the status	in U.S. 13. V	211 /as Decedent of Hispar		s or No-	USA 14. Race - Ame	arioan Indian
21213-0036 within 72 hours after de	al Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.	If	/as Decedent of Hispar Yes, specify Cuban, M ☐ Yes 2 🙀 No Sø		etc.)	Black, Whit	
5-0	"natu dical	plete	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupation ind of work done during		16b	. Kind of Business	
1.27 hin 72	ne. than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	nation/Refe nation/Refe		1 '	ltimore	
N M	tal Hygiene ed other th event, the	a l	17. Father's Name (First, Middle, Last)	Intorn	· · · · · · · · · · · · · · · · · · ·			d Welfar	e
Be file	- π Ψ I	To I	Josef Ibisch			Mother's Name (First, nna Durst	iviidale, ivialde	en Surname)	
Maryland 2 should be filed	th and Mental 27 is marked traumatic ev		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and N		Number, City	or Town, State, Zi	p Code)
	= 21 = 1		Helen Witherill Daughte	1	Pine Stree			80302	
o	of Healt If item 2 or other			0b. Place of Dispos		Date		Location - City or	Town, State
Pag	tment tant: jury o			•	remations	1/7/2011	. 1	Hampstead	i, MD
baltimore,	Department of H Important: If ite any injury or ot once.		21. Signature of Fineral Service Licensee J. Wayne Oste	- a	Name and Address of line Funer	, I		eistersto stown, M	
			23a. P t 1. Enter the c seas , complications that caused the shoo , or heart failure. List only one cause on each line.	death. Do not ente	the mode of dying, su				Approximate Interval Between
	/sician/		Immediate Cause Film disease or condition	EUMON	A				Onset and Death
	Medical aminer		Due to (or as a con	nsequence of):					41.4.
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con	JG CAN	CER				UNKNOWN
rted	dansit	Examiner	cause. Enter Underlying Cause (Disease or impury						
5 8	ng physician and as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a con	nsequence of):	· · · · ·				
ate be	hysici the bu	dica	d			·····			
oo/ou	ding p	₩e	IF FEMALE: 23c. If yes, outcome of pr	regnancy	·				
death o	e atten	Physician/Medical	in the past 12 morths? 1 \subseteq Live Birth 2 \subseteq Region Live Birth 2 \subseteq Region Live Birth 2 \subseteq Region Live Birth 2 \subseteq Region Region	Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
it c	d by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but no	ot reculting in the ur	rdarlying async given in	Port I on			
us, r.	been signed by the attendin should be detached for use a	ed by	Part in Other significant continuous continuous to death but no	or resulting in the tr	denying cause given in				the cause of death?
Records, The law required	as be	Completed				24	la. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The T	page	5				1	performed?	death?	s 2 🗆 No
VITAII ysician:	certific ector,	Be	25. Was case referred to medical examiner?		Other	of Death (Check only or	ne)		
Phys	er ucann. ector : After this certificate has by the funeral director, page 2	<u>은</u>	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatient 28b. Time of	3 DOA Other. 4	Nursing Home 5	Residence		eify)
nding	: Afte	cate	1 Natural 5 Pending (Month, Day, Yea 2 Accident Investigation	ar) injury	work? M 1 🗆 Yes		scribe now inj	ary occurred	
al or Attending P	rector by th	Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - 4 building, etc. (Sp.		et, factory, office			and Number or Ru	ral Route Number,
italo li	ral Di lled in						y or Town, Sta		
DIVISION OF VICES RECORDS, P.O. BOX 08/00 CM. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Dir	Medical	29a. Certifier (Check (Check only one) Certifying Physician: To the best of my k Wedical Examiner: On the basis of examination only one) Certifying Nurse Taglioner: To the best	nation and/or investig	ation, in my opinion, de	eath occurred at the time	e date and plan	ce, and due to the	cause(s) and manner stated
Tot	To t		29b. Signature and tife of certifier	1	29c. License num		1	Oate signed (Monti	
	10	ŀ	30. Name and address of person who completed cause of death	(Item 23a) (Type, Pr			UPI	TURKET 5	- I
	10			401 04	D COURT 1	RD RANDA	USTOW	M MD	21133
	Stat Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Physician/ 1am Konald 1710 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death of Mary Vard Medical System Baltimore City 6. Sex 1 ☑ M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, May 13, 1 Birthplace (State or Foreign Country) **Funeral** Hours Yrs. **Director** 66 215**-**40-9805 Usual Residence of Decedent or 28a-f show notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Owings Mills ò 10e. Street and Numbe 10g. Citizen of What Country? be must be Funeral 11 Byway Road 21117 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iter I Examiner ı Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. "natural" Completed 3 Divorced 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Glve kind of work done duning most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Cloverland 12 Truck Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Heiland Anna Goodrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Sue Heiland 11 Byway Road, Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 1 - 18 - 11Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road SCO. Pin Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mudicavola disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a con guence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been along the control of the Funeral Director. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Yes 2 No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09,2011

Registrar DHMH 17 Rev 7/2009

State

Baltimore, MD

21201

S Greene Street

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oert Hinkle		State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Registrar Reg. No.
Physici		1. Decedent's Name (First, Middle, Last) Robert Lee Hinkle Jr. 2. Date of Death Month Day Year
dical Exam	iner	Robert Lee Hinkle Jr. Robert Hinkle January 5, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		402 E. Lincoln Ave Apt C Salisbury Wicomico
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		218-60-3102 12 M 2 F 56 Yrs. Months Days Hours Min. 08/20/1954 Foreign Country) MD
		Usual Residence of Decedent
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
yland -f sho	tor	MD N/A Salisbury
c Maryland or 28a-f sho	Director	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	a D	Division St. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
eath w items	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
fter d	_	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White
ours a atura xamir	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
6 172 h 20 "n cal E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
within tiene.	Ē	1. Father's Name (First, Middle, Last) 1. Father's Name (First, Middle, Maiden Surname) 1. Father's Name (First, Middle, Maiden Surname)
filed all Hyg	Be C	
212 uld be Mentz mark	O.	Robert Lee Sr. Mary unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica		Tina Hinkle(wife) 34580 E. 521 Deck St., Millsboro, DE19966
e, land land Healt litem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I as Department of Hee Important: If ite		1 Burial 2 A Cremation 3 Removal from State Joseph of the Park F/H And Crematory 01/07/11 Baltimore, MD
altir mit. I partme		Dollation 5 Other Specify.
E E E	- 3	21 Signature of Funeral Service Licensee 22 Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Combined Drug Intoxication Involving Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease a. Oxycodone, Cocaine, Olanzapine, Trazodone, Paroxetine, Death
		or condition resulting in death) Due to (or as a consequence of). Meprobamate, and Carisoprodol
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c
ted I Insit		events resulting in death) Last Due to (or as a consequence of):
on of Vital Records, P.O. Box 68760, anding Physician: The law requires that the death certificate be executed ath. 77. After this certificate has been signed by the attending physician and he funeral director, page 2 should be detached for use as the burial - transit	ledical	▼ AMENDED 1,23a,27,28a-f per me c912 2-15-11 vt 1 per me g912 2-16-11 vt
60, ate be hysici e buri	Med	I per me g912 2-16-11 VL IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box 68760, death certificate be he attending physic of for use as the bunder of the purpose of t	Physician/N	23b. Was decedent pregnant in the past 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
OX (eath ce	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown
D. B. t the de by the	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O. ss that the greed by the detac	ğ	1 Yes 2 ✓ No 3 Probably 4 Unknown
ds, equire een si ould b	Completed	24a. Was an 24b. Were autopsy findings available
COF law r has b	ğ	autopsy prior to completion of cause of performed? death?
in: The rrificate for, pag		25. Was case referred to medical 26. Place of Death (Check only one)
Division of Vital Records, talor Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should it.	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene
Jof Ving Phy	\vdash	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion tendir eath. tor: A	ţį	Natural 5 Pending Fd 1_5_11 Fd 7.58am 1 Yes 2 No unknown
ViSI or At fter d Direct in by	ertification:	Accident Investigation 1 28. Place of Injury - At home, farm, street, factory, office building, etc. Suicide 6 Could not be determined of the country of th
Divis pital or At ours after d teral Direct	Cert	4 Homicide determined (Specify) dwelling Salisbury, Md.
DIVI. To the Hospital or within 24 hours after To the Funeral Dirt. completely filled in b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the How within 24 h To the Fur	Medical	and manner stated.
	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Cielos Valle S/edi O.C.M.E. January 6, 2011
		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
3	tate trar	31. Date filed (Month, Day Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 20 | 1 Month Physician/ 1604 nn Johnson AM 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Centre Raltimore NA If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 1 XXXM 2 □ F Months Hours Min Country) 218-74-7479 Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at **Funeral Director** 1 🕅 Yes 2 🗌 No MD NABaltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21217 USA Dolphin Street Apt.#1016 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.African "natural", or item I dical Examiner n 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No þ 1 X Never Married 2 Married 1 Yes 2 d If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: American Completed 3 Widowed 4 Divorced other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Chef 10th Grade NA Be 27 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eunice Carter Johnson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Marine Oaks Drive Essex, Maryland Darlene Johnson-Daughter tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1
Department of Important; If it any injury or of once. 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cem 01-13-11 Lansdowne. 21. Signature of Funeral Service License Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 a. Part 1. Enter the disease, or complice shock, or heart failure. List only on ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Scphc Shock disease or condition Medical resulting in death) **Examiner** vanab Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that initiated events Due to (or as a consequence of): physician a s the burial-t resulting in death) Last Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖭 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an s certificate has I lirector, page 2 s autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No M Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined filled in t within 24 hours at To the Funeral D completed filled in To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier January, 07, 2011

State Registrar

DHMH 17 Rev 7/2009

South

22

Guene St.

Baltimor, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

32. Kegistrar's Signature

arker

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death OCKSON Physician/ Month / N. 825 50 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death KINS Duyview Da 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Ye 1 🗆 M 2 📝 212-26-7690 83 Mary land Director Usual Residence of Decedent show 10a. State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 🗆 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 South Lane 21222 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3X Widowed 4 □ Divorced Black. Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Clerk Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Bentley Rufus Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Denesia Jackson (Daughter) 9 South Lane Dundalk, Maryland Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Hilltop Service Corp 1/11/2011 4 Donation 5 Other (Specify) Towson, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility uda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Firlal MIMINORY Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ein mould Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limitury that initiated several limitury) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

Just after death.

filed in by the funeral director, page 2: autonsv 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Year Koch Louise Antoinette 2011 7:45 Tan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7314 German Hill Road Baltimore Dunda1k 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Year) 29,1935 1 □ M 2 🕱 F Months Days Hours Min 219-32-6157 Yrs Maryland Director Nov. Usual Residence of Decedent 28a-f show 10b. County ä 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified 1 Ves 2 X No Dunda1k MD Baltimore ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 21222 7314 German Hill Road death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 ģ 1 Never Married 2X Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify. "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Florist/Greenhouses Owner of Dundalk Florist 11 Years traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernadette Luckert should be Martin Komornik 19a. Informant's Name/Relationship (Type, Print) Pus an 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. August H. Koch, Jr. 27 7314 German Hill Road Dundalk, Maryland 21222 Page 1 and 2 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Towson, Maryland Service Corp. 1/14/2011 4 Donation 5 Other (Specify) Hilltop Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) UNCER Due to (or as a con Medical Examiner Sequentially list conditions, if any, leading to mini ediate cause. Enter Underlying Examine July to for as a consecuence of attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate has 1 Yes 2 No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature nd title of certi-29c. License number 29d. Date signed (Month, Day, Year) WV 10 2011 140854 30. Name and address of person who compreted cause of death (Item 23a) (Type, Print) 227 St. Paul Place David Reisberg, M.D. 21202 Baltimore, Maryland

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 1 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Robert Charles h		1- For State	State of Maryla		artment of rtificate of		nd Ment	al Hygiene	2 () Reg. No.	1 00302
Physicia	_	1. Decedent's Name (First, Mic	idle,Last)					2. Date of D		3. Time of Death
Medical Exami	ner	HODELE GIGILE	es Kohlbus				Month January 6,		0606 hrs	
		4a. Facility Name (if not institu		ımber)	'	b. City, Town,		f Death	4c. County of	Death
		Harford Memorial Ho	·			Havre De			Harford	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 You Months Da	ear If Under ays Hours	24Hrs. 8. Date of Min.	Birth(MM/DD/YYYY)	9. Birthplace (State or Foreign Pennsy Ivania
Director		198-30-3615	1 M 2 F		70 Yrs.	I WOTE TO	ays riours	July	17, 194 0	Country)
E	ŀ	Usual Residence of Decedent 10a. State 10b. Count		I10c City	, Town or Locati	00				10d. Inside City Limits
_ A				l co. Oity						1 Yes 2 No
yland Lonce	흱	Maryland Ha: 10e. Street and Number	rford		Aberdee	10f. Zip Code			10g. Citizen of Wha	
or 28	Director	723 Carsins R	un Dood				001		USA	-
death with the Maryland or items 23a or 28a-f show must be notified at once.		12. Marital Status		cedent Ever in U	S 13 Wa			n? (Specify Yes or I		American Indian, Black,
ath w	Funeral	1 Never Married 2 X	Married Armed F	orces?				Puerto Rican, etc.)	White,	
ter de		3 Widowed 4 D	1 Yes Divorced If Yes, Give Yes	2 X No	1	Yes 2 X	lo specify:		Specify:	White
21215-0036 and be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	d b	15. Decedent's Education (Sp	or Dates: pecify only highest grad	de completed)	16a. Decedent	's Usual Occup	ation (Give k	ind of work done	16b. Kind of Busi	
72 hc	흥	Elementary/Secondary (0-12	College (1	1-4 or 5+)	during mo	st of working li	fe. DO NOT u	use retired)		
O3(vithin ene.	Completed	11			Labor	er			Fact	cory
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middl	. ,					Name (First, Middle		
d be f fental	Be	Charles Koh			1 101 11 11	411 (2)		ra Pierso		
	٩	19a. Informant's Name/Relation		fo					umber, City or Town, een, Mary]	
and 2 ealth :	ŀ	Sylvia L. Ko	onitous, wr		Place of Disposi			Date Date		ity or Town, State
MOFE, Pages 1 a tent of He tut: If ite		1 Burial 2 X Crematic	on 3 Removal fr	om State	crematory or oth	er place)	~			•
timent rant:		4 Donation 5 Other	Specify:	Met	tro Cre	natory	Inc.	01/10/11	Baltimo	ore, Maryland
Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 in injury or other traumat	-	21. Signature of Funeral Service	e Licensee Thom.	as Grego	or Cre	eme and Addre	Socie	ty Of Mar	yland, Ind	iand 21228
Physician	\dashv	23a. Part I. Enter the disease, of	or complications that ca	aused the death	Do not enter th	frede:	CICK K	Oad Balti	more, Mary	/Land ZIZZ8 Approximate Interval
Medical		failure. List only one caus	e on each line.							Between Onset and Death
Examiner	- 1	Immediate Cause (Final diseas or condition resulting in death)		consequence o		lerotic	Cardi	<u>lovascular</u>	Disease	
		Sequentially list conditions,	b	1						
	힐	if any, leading to immediate cause. Enter Underlying Caus-		consequence o	f):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	C	consequence o	f):					
cuted nd transit			d							
be executed isician and urial - transi	dical	X UNPENDED	☐ AMENDED 2	23a,27,p	er me,g	916 6-7	−11 sπ	1		
	€ .	IF FEMALE: 23b. Was decedent pregnant in	tho	outcome of preg	nancy				23d. Date of de	•
68 certifi nding se as	ië ,	past 12 months?	I I Elle B	irth ant at time of de	ath -	al death 3	Ectopic	pregnancy	Month	Day Year
Box 6876(e death certificate the attending phys ed for use as the b	Physician/Me	1 Yes 2 No 9 U	nknown 9 Unkno		5 Oth	er (Specify)		,		
cords, P.O. B. (aw requires that the de has been signed by the 2 should be detached f		Part II. Other significant cond	itions contributing to	death but not re	esulting in the ur	nderlying cause	given in Parl	1. 23e. Did	tobacco use contribu	ite to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter cleath. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.	d b							1 Y	es 2 No 3	Probably 4 🗹 Unknown
rds requi	Completed							24a. Wa		re autopsy findings available or to completion of cause of
tal Records cian: The law requi certificate has been	튑	-							formed? dea	ith?
T. T. Tiffica	ပ္ကို-	25. Was case referred to medic	al	_		26.Plac	e of Death (0	Check only one)	2 10 1	Yes 2 No
Vital Recysician: The Institute of the I	o Be	examiner?	Hospital: 1	npatient 2	ER/Outpatient		Othor		Residence 6	Other:
Of Ving Physical After this uneral dir	- $+$	27. Manner of Death	28a. Date	of Injury Day,Year)	28b. Time of In	jury 28c. Inj	ury at Work?	28d. Describ	e how injury occurred	
ion tendii for: /	흹		nding estigation	, = 4), (441)		1	Yes 2	No l		
ivision or Atten after deat Director:	<u></u>			e of Injury - At ho	ome, farm, street	, factory, office	building, etc.	28f. Location or Town,		or Rural Route Number, City
Division of oppital or Attending Phonus after death. Internal Director: After ty filled in by the funeral	Certification:	4 Homicide	ermined (Specify)					G TOWN		
2 - 2 - 2			Physician: To the bes aminer: On the basis of							
To th within To th	Medical	2 wedical Ex	and manner st	tated.			in, death occu	uneu at the time, dat		
	2	250. Signature and little of certif	ICI				.M.E.			(Month, Day, Year)
		U-"UL					.ivi. .		January 7, 20	711
1 opins		 Name and address of perso Donna M. Vincenti, N 	110	e of death (Item ledical Exan		V. Baltimor	e Street F	Baltimore, MD 2	21223	
	ate	31. Date filed (Month, Day, Year		gistrar's Signatu			_ U.1001, L			
Registi		JAN 1 1 201	1 /	h h	har that					

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items# 1.5. per phy & fh. 2917 7-8-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert Lewis Kennedy Month Year 10:45A M Robert Physician/ TAQUAY? 2011 Medical 4c. County of Death Baltimore Facility Name (if not institution, give street and number) Sity Town or Location of Death **Examiner** 05 town . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Funeral Months Days Hours Min. (Month Country) 1 M 2 D F Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside Citv₄.imits with the Maryland at Director other traumatic event, the Medical Examiner must be notified 1 Yes 2 ☐ No MD timore P 10e. Street and Numbe. 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Buban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Yes 2 No "natural", or ò 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 3 ₩ Widowed 4 □ Divorced Completed within 72 hours 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me -BO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Be filed 17. Father's Name (First, Middle, Last) ည Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٥د 406 Page 1 and 2 lona 20b. Place of Disposition (Name of cemetery, crematory or other, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) onardtown 21. Signature of Funeral Service Dicense Name and Address of Facility eene Funeral Services mD 21/33 23a. Part 1. Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Cardiomyopathy Onset and Death Immediate Cause (Final End-Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 the attending phone of the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown g Unknown Records, P.O. as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N page certificate 2 🗌 No 1 🗌 Yes 25. Was case referred o medical Be Division of Vital funeral director, 26. Place of Death (Check only one) Hospital 4 - Nursing Home 5 - Residence 6 - Other (Specify) ent hospice 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA မ After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending work To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

MS Lyapanie M.D. 29d. Date signed (Month, Day, Year) 10057465 1/6/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203, Baltimor, 140,71209 28355mith Av-S. Rayapakse, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Willie Otto Kent 2:474 M Donne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Baltimore Washington Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{(Month} Sep 6, 1946 ₩o.tocarolina **Director** 64 238-70-4125 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director X 1 \sum Yes 2 \sum No Severn Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral U.S.A. 21144 554 Queenstown Road Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.

is marked other than "natur raumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Church Elementary/Seconday (0-12) College (1-4 or 5+) Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian B. Kent 2 Elbert Kent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 554 Queenstown Road Severn, Maryland 21144 Gwendolyn Kent Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Upper Marlboro, Maryland 01/08/11 4 ☐ Donation 5 Other (Specify) St. Luke Cemetery 22. Name and Address of Facility 21. Si at la funeral Service Licensee Estep Brothers Funeral Service, P. 1300 Futaw Place Baltimore, Md Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MON Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Completed by Physician/Medical Examiner Due to lor as a consuluence of cause. Enter Underlying Cause (Disease or linjury for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural work? 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one title of certifier 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depa		ental Hygie	ene	00305
			Tioglotta.	ificate of Death	Reg	J. No U 1	00303
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Medic		Arthur Paul Kraeski		January	10 2011	12:19 P M
	Examin	er		4b. City, Town, or Location of Death		4c. County of Death	٦
5			9222 Old Scaggsville Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Laurel If Under 1 Year If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
	Funeral Director		220-26-7198 1X M 2 🗆 F 83 Yrs.	Months Days Hours Min.	(Month, Day, Ye	ear) Cou	intry)
-			Usual Residence of Decedent		SPILL OF	1727 1101	
	yland f sho ed at	to!	10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	e Mar r 28a- notifi)ire	MD Howard Laurel 10e. Street and Number	10f, Zip Code	Lie	0111	1 Yes 2 X No
	ith the	Funeral Director		ı i	100	g. Citizen of What Co	untry?
	ath w	nue	9222 Old Scaggsville Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	as Decedent of Hispanic Origin? (Speci	ifv Yes or No-	USA 14. Race - Amer	rican Indian
ထ	er de	by F	Armed Forces? If ¹ 1 X Never Married 2 ☐ Married 1 X Yes 2 ☐ No	Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	Black, White	e, etc.
<u></u>	ırs aft ıral", I Exa	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	Yes 2X No Specify:		Specify: W	hite
5	2 hou "nata edica	Completed	(Specify only highest grade completed) (Give kii	ent's Usual Occupation and of work done during most of working	~	b. Kind of Business I	
12	thin 7	Son	Elementary/Seconday (0-12) College (1-4 or 5+)	NOT use retired) strative Office Ma		tuxent Wi	
р 5	ed wi Hygid other ent, t	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name			licer
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To	Martin J. Kraeski		ine Clar		
ary	hould and M s ma		19a. Informant's Name/Relationship (Type, Print) 19b. Malling	Address (Street and Number or Rural I			Code)
	C = 0 :		Kathleen M. Miesse / Niece 3327 S	Stuart Road, Adki	ns, TX	78101	
ore	e 1 and of Hea If item or other	- 3	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremation 3 ☐ Removal from State	ition (Name of atory or other place) Jan •	ate 14,	c. Location - City or	Town, State
<u>Ē</u>	. Page 1 tment of tant; If it jury or o		4 □ Donation 5 □ Other (Specify) St. Mary	s Cemetery 201	1	Laurel, M	
Baltimore,	permit. Page 1 Department of Important; If i any injury or once.		1 2 44 4 4 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Name and Address of Facility Don			
_	20210		20a Best State the disease or complifications that caused the death. Do not enter	313 Talbott Avenue	, Laure	elMD 20	707 Approximate
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.		respiratory arrest	·	Interval Between Onset and Death
	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death) Levelra L Due to (or as a consequence of):	h Rombosis			mmuler
-	Examiner		Congestive Heart	Failure			weeks
		Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying				
	cuted nd transi	xam	Cause (Disease or iinjury that initiated events C. Coronary Artery D)isease			years
	ate be executed hysician and the burial-transit	alE	resulting in death) Last Due to (or as a consequence of):				
9	physic the b	edical	d				
89	ding se as	Z/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	iverv
ŏ	eath c atter	Physician/Me	in the past 12 months? 1	Ectopic pregnancy Other (specify)		Month	Day Year
——————————————————————————————————————	the do	hys	9 Unknown				
Records, P.O. Box 687	s that gned	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to	
ds,	equire sen sig ould k	ted	Pulmonary Fibrosis		1 L Yes		robably 4 A Unknown
00	law re nas be e 2 sh	Completed			24a. Was an autopsy	prior to o	topsy findings available completion of cause of
æ	: The cate I				performe 1 Yes 2	ed? death? No 1 Yes	2 🔼 No
ta	sician certifi rector	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Qutpatient	26. Place of Death (Check of Death)			
	this aldi	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at 28	ne 5 X X Residend 3d. Describe how	ce 6 Other (Speci injury occurred	ify)
<u>></u>			1XXNatural 5 ☐ Pending (Month, Day, Year) injury	work?			
on of V	nding F ath. r: After ie funer	icat	2 Accident Investigation	M 1 Tes 2 No			
vision of V	r Attending F ter death. rector: After by the funer	ertificat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street			et and Number or Rui State)	al Route Number,
Division of Vital	ital or Attending F urs after death. ral Director: After lled in by the funer	al Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	City or Town, S	State)	
Division of V	Hospital or Attending F 24 hours after death. Funeral Director: After sted filled in by the funer		2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investig	et, factory, office 2i ccurred at the time, date and place, and gation, in my opinion, death occurred at the	due to the cause he time, date and	State) (s) and manner as sta	ited. cause(s) and manner stated.
Division of V	o the Hospital or Attending F vithin 24 hours after death. o the Funeral Director. After ompleted filled in by the funer	Medical Certificate	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) 29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death or	et, factory, office 2i ccurred at the time, date and place, and gation, in my opinion, death occurred at the	City or Town, S due to the cause he time, date and , and due to the ca	State) (s) and manner as sta	ated. cause(s) and manner stated, stated.
Division of V	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify) 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investion only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death or	et, factory, office 22 22 22 22 22 22 23 24 25 26 26 27 27 28 28 29 20 20 20 20 20 20 20 20 20	due to the cause he time, date and u, and due to the ca	State) (s) and manner as stated blace, and due to the cause(s) and manner as	ated. cause(s) and manner stated. stated. n, Day, Year)
Division of V	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer		2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify) 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investion only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death or	et, factory, office coured at the time, date and place, and gation, in my opinion, death occurred at the time, date and place, 29c. License number D13916	due to the cause he time, date and u, and due to the ca	(s) and manner as sta place, and due to the c ause(s) and manner as d. Date signed (Month	ated. cause(s) and manner stated. stated. n, Day, Year)
Division of V	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier 29a. Certifier 1	coured at the time, date and place, and gation, in my opinion, death occurred at the time, date and place, and coursed at the time, date and place, 29c. License number D13916 int) and, Laurel, MD 20	due to the cause the time, date and ju, and due to the ca	(s) and manner as sta place, and due to the c ause(s) and manner as d. Date signed (Month	ated. cause(s) and manner stated. stated. n, Day, Year)
Division of V	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify) 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigonly one) 3 Certifying Nurse Practioner: To the best of my knowledge, death or conjugate the properties of the properties	coured at the time, date and place, and gation, in my opinion, death occurred at the time, date and place, and coursed at the time, date and place, 29c. License number D13916 int) and, Laurel, MD 20	due to the cause the time, date and ju, and due to the ca	(s) and manner as sta place, and due to the c ause(s) and manner as d. Date signed (Month	ated. cause(s) and manner stated. stated. n, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 30M Month Year Physician/ NNE SAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COLUMBIA COUN 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Security Number Age (In yrs. last birthday) **Funeral** May 15, 1917 1 □ M 2**X**XF Min Country) CA 577-24-5586 93 Director Usual Residence of Decedent shov 10d Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State Director West Friendship 1 ☐ Yes 2 🛣 No Howard MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21794 2587 Wellworth Way 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Yes 2 No Specify Specify: white 3xxWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Emma Weber William M. Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2587 Wellworth Way, West Friendship, MD 21794 Department of Health Important: If item 27 any injury or other to David C. Kroop/ Son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Jan Date 10. cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State West Arundel Crem. 2011 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Rome, P.A. . Signature of Funeral Service Licensee 313 Talbott Ave., Laurel, MD 20707 · Ken M01053 Rot 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death ed by the a detached f 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed l page 2 should be det þ Records, 1 🗌 Yes 2- No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 2 P No Yes Yes 25. Was case referred to medical **Division of Vital** director, 26. Place of Death (Check only one) Be examiner? Other: 2 11 140 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) work?
1 Yes 2 No 5 Pending 1 Natural M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral of

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00307 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 12:45 P M Mary Louise Kirby January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 754 Old Herald Harbor Road Crownsville 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Numbe Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) 08-02-1917 Months 1 M 2 X Director 218-07-1361 93 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No Crownsville MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21032 United States 754 Old Herald Harbor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. ş 1 Never Married 2 Married "natural", or Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72., and Mental Hygiene. Anne Arundel Elementary/Seconday (0-12) College (1-4 or 5+) County Government Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Elizabeth Anderson Vance Marshall or other traumatic 1 and 2 should be of Health and Mee item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 754 Old Herald Harbor Road Crownsville, MD 21032 Lillian E. Forney / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Burial 2 Cremation 3 Removal from State MD Veterans Cemetery : 01-07-2011 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 2. Name and Address of Facility
Donaldson Funeral Home & Crematory, Will Expour Annapolis Road Odenton, Maryland 21113 1411 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Privsician/ Advanced Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant • Hospital or Attending Physician: The law requires that the death to 24 hours after death.
• Funeral Director: After this certificate has been signed by the atterested filled in by the funeral director, page 2 should be detached for united filled in by the funeral director, page 2 should be detached for united filled in by the funeral director, page 2 should be detached for united filled in by the funeral director. in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension 1 Yes 2 No 3 Probably 4 W Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 💢 No 1 🗌 Yes 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 X Natural 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title nD D50470 January 05, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7310 Ritchie Highway, Suite 800, Glen Burnie, MD 21061 Sridhar Atluri, M.D., 31. Date filed (Month, Day, Year) Registrar's Signat State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ionth Physician/ OGER aw RPNCP Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Northwest Hospital Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Month Day, 1934 1 ₺ M 2 🗆 F Months Hours Mary land Dec Director 217-64-0492 56 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Yes 2 No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA Funeral 3931 Ridgewood Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14 Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married þ Specify: black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 K No Specify "natural", 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 truck driver transportation 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Carrington Mack Koger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1942 Frames Road; Dundalk, Maryland 21222 Mia Koger - daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state cemetery, crematory or other place) injury or 22. Name and Address of Facility State Anatomy Board Signature of Funeral Servi e Licensee S. Wade 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ uman disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physiclan a for use as the burial-Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 □ Probably 4 □ Unknown 1 Yes cate has been signated by page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Suicide Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Folker Kelly, J	1- For State Registrar	Sta	te of Maryla		artment of ertificate of		Mental H		eg. No.	011	00309
i ilyototatii	1. Decedent's Nam	ne (First, Middle,	Last)					2. Date of Dea Month	_	Year	3. Time of Death
Medical Examiner	2002		Folker				r.	January 8	3, 2011		0614 hrs
			give street and nul Medical Cent		ľ	lb. City, Town, or L Baltimore	Location of Deati	n	4c. Cou	nty of Death	
Funeral	5. Social Security			7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of Bi	rth (MM/DD/Y	YYY) 9. Birti	hplace (State or
Director	212-94-1	414	1∑M 2□F	-	32 Yrs	Months Days	Hours Mir). No soubc	r 25, 1	Foreign Cou	nuntry)Maryland
	Usual Residence o) <u>Z</u>			novano	1 20, 1	7/9	Haryrana
v any	10a. State	10b. County		10c. City	, Town or Locat						10d. Inside City Limits
Maryland Maryland 28a-f show d at once.	Maryland		timore			Chase					1 Yes 2 XNo
Le Le International and 18a-f sh iffied at once Director	10e. Street and Nu		beec			10f. Zip Code	20	1	0g. Citizen o	f What Coun	try?
					10 L10 M/s	212:			USA	A	an Indian Disab
r death with or items 23 must be no	11. Marital Status 1 XNever Marri	ed 2 Man	ried Armed Fo			s Decedent of Hisp es, specify Cuban,				vhite, etc.	can Indian, Black,
r, or i	3 Widowed		1 Yes ced If Yes, Give Year	2 X No	1	Yes 2X No	specify:		Spec	ity: Whi	te
urs aft ttural" amine	15. Decedent's E		y only highest grad		16a. Deceden	's Usual Occupation	on (Give kind of			f Business/Ir	
6 72 hc	Elementary/Seco	ondary (0-12)	College (1-	-4 or 5+)		ost of working life.					
5-0036 ed within 72 hour yygiene. other than "natt he Medical Exan	12 years				Heav	y Equipme				ructi	on
21215-0036 Juld be filed within 72 hours Mental Hygene. marked other than "nature te event, the Medical Exam To Be Completed 18	17. Father's Name Paul F. 1		ast)			1	8.Mother's Name Betty 1	, , ,	Maiden Surna	ame)	
2121 ould be fil ould be fil is marked tic event, To Be	19a. Informant's Na	-	p (Type, Print)		19b. Mailing	Address (Street			nber, City or	Town, State,	Zip Code)
s, MD 2 and 2 shoul lealth and N tem 27 is m traumatic	William 1	Kelly	Brot	her	2557	Liberty 1	Parkway	, Dundal	k, Mary	land	21222
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Med	20a. Method of Dis					tion (Name of cem		nuary	20c. Locati	on - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		Other Spe	3 Removal fro			rematory		, 2011	Balti	imore,	Maryland
Baltin permit. P. Departmet Importan injury or	21. Signature of Fu				22. N	ame and Address	of Facility	Jomo Of	Dundal	lk D A	
E. P. D. B. OD	Joh	Ch. VI	raio	M0117	71	ame and Address nnelly Fi 10 Solle	rs Point	Road,	Dunda.	k, MD	21222
Physician		ne disease, or co lly one cause or	omplications that can each line.	used the death	n. Do not enter th	e mode of dying, s	such as cardiac o	or respiratory arr	est, shock, o	r heart	Approximate Interval Between Onset and
` /Medical ∠xaminer	Immediate Cause (a. Narcot			and Mor	hine) I	ntoxica	tion		Death
	or condition resulti		Due to (or as a	consequence o	of):						
Je Je	Sequentially list co if any, leading to in	nmediate	b. Due to (or as a	consequence o	of):						
Insit Examine	cause. Enter Unde (Disease or injury t	that initiated	c. Due to (or as a	consequence	νη·						
E asi e d	events resulting in	death) Last	d.	consequence	J. j.					· ·	
be executed dician and urial - transit	X UNPENDED		AMENDED	23a,27,	28a-f p	er me g9	13 3-2-	11 vt			
760, cate bo	IF FEMALE:		23c. If yes, o	utcome of preg	gnancy			-	23d. Dat	e of delivery	
687 certific ading se as t	23b. Was decedent past 12 months		1 Live bi	rth ant at time of de	noth ~ 🗔	aldeath 3 L	Ectopic pregna	ancy	Mont	h D	ay Year
h. Box 68760 the death certificate by the attending physiched for use as the buPhysician/Me	1 Yes 2 1	No 9 Unkno	T [5 Otl	er (Specify)					
O. E at the tached tached	Part II. Other signi	ficant conditio	ns contributing to	death but not r	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
, P. (ires that signed be det								1 Yes	2 🗸 No	3 Proba	ably 4 Unknown
rds v requisional	ĺ							24a. Was autop			opsy findings available ompletion of cause of
Records, The law requires ficate has been sign, page 2 should be Completed					_			perfo 1 ✓ Yes	rmed?	death? 1 ✓ Yes	2 No
al R au: T stor, p	25. Was case refer	red to medical					of Death (Check				
F Vitz Physicia or this ce ral direc		2 No	Hospital: 1 Ir	npatient 2 🗸	ER/Outpatient			ng Home 5	Residence	6 Other:	
n of ling P After funers	27. Manner of Deat			of Injury Day,Year)	28b. Time of Ir			28d. Describe	how injury oc	curred	
Sion Attend death cror: by the	2 Accident	5 Pendin Investig	gation Lu 1-		fd 5:24	am	es 2 X No	unknow			
Division of Vital Records, P.O. Box 68760 spital or Attending Physician: The law requires that the death certificate behaves after death. neral Director: After this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the but Certification: To Be Completed by Physician/Me	3 Suicide	6 X Could i	not be		ome, farm, stree	t, factory, office bu	iliaing, etc.	or Town S	tate) 783	5,Jame	al Route Number, City sford Rd.
	4 Homicide 29a. Certifier	Certifying Phy	1	house	Ige death occur	ed at the time date	e and place and				
4 E B B C Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur											
Me G G G	29b. Signature and	title of certifier	and manner st	ated.		29c. License	number		29d. Date s	signed (Mon	th, Day, Year)
	Mour	0-10 M	m. March	?		O.C.M	1.E.		January	9, 2011	
0	30. Name and addr				-						
4	Margarita K	orell MD.	Assistant Med			Baltimore Str	eet, Baltimo	re, MD 2122	3		
State Registrar	a 51 10/6 (EVA 40) to A	th Day, Year)	32. Reg	gistrar's Signati	ure						
	ت ا	1	treve 1	. Soci	ORIGINAL					001	ME
DHMH 17 Rev 1/2001					UKIGINAI	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per FH G911 1/11/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 8 Day 2011 Year Physician/ 9:45 Ρм John Lewis Kirk, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours 1 ★ M 2 🗆 F 0177771929 Virginia 230-32-8697 81 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 U.S.A. 15 Honeycomb Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

144Yes 2444 Korea
If Yes, Give
Year or Dates. 1951-52 Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2XXNo Specify: 3 Midowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Eastern Stainless Corp Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella May Dye Worley Lewis Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Prestwick Trail, Bel Air, Md. 21014 John L. Kirk, Jr. (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gard. 01/13/2011 20a. Method of Disposition 20c. Location - City or Town, State 122 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disse or condition reulting in death) ₹nysician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Denydration 2 WNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tes Diarrhea 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 3 🔲 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/9/2011 H0062765 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)
NESVEEN KUV TOM 500 Upper Chesapeake Drive Bei Air, mp 21014 10/1 31. Date filed (Month, Day, Year) State Registrar

700 2145

000

M800519773

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2011 lanuary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Aug 24, 1 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F Maryland 81 Director 212-24-9107 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show must be notified at 1 Yes 2 No Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip-Code 10e Street and Number United States 21044 or items 23a 5399 Iron Pen Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 No If Yes, Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Year or Dates: 1952-54 "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Advertising Art Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) other traumatic event, Be Mental and Mental Elizabeth Smeton Kramer Anna William Henry P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Columbia, Maryland 21044 Rowland Scott Kramer/son Court 5510 Mystic 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6 Department of Important: If any injury or once. Journey Crematory 1/12/2011 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Final Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licensee this mas Beverly L. Heckrotte, P.A. Clarksville, MD 21029 canita () M00957 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heart **Physician** attack disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner artenu Due to or as a consequence of Sequentially list conditions, if any leading to in reclair cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Tinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records. 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After t 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 danuary 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

CHO

31. Date filed (Month, Day, Year)

JAN 11 2011

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 UG 0452 Cel Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8002 Laurel Bowie Road Bowie Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) ept 6, 1955 Washington, DC Sept Director 212-68-5389 55 Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2 ☐No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8002 Laurel Bowie Road 20715 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. è 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀No Specify: Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Drywall Mechanic Construction event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Patrick Constance Ann Kiatta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Miller/Sister/POA 8002 Laurel Bowie Road Bowie, Maryland 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/8/2011 Woodbine, Maryland Sign are of Funeral Service Ligenses 22. Name and Address of Facility Going Home Cremation Service Beverly L. Heckrotte, P.A. C. Diamas M00957 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ IVER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Exami or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No Yes funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Tyes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ompleted filled in by the fireinjury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nature and title of**∄**ertifi m ho completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

ICHAEL

(Month, Day,

m un

face

32. Registrar's Signature

EN 3

6

amend item 19a per beinftment of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1306AM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town. or Location of Death 4c. County of Death **Examiner** Hos N/A Harbor imore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 11/28/192 1 🗆 M 2 🔀 F 213 20 6364 87 Pennsylvania Director Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛛 No Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5218 Kramme Avenue 21225 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural", Completed 3 XWidowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Products Sales 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin O. Somerville Cora Ethel Young 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 436 Obrecht Road Millersville, Maryland 21108 Louis Bohdal / Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland Glen Haven Mem. Park 01/07/2011 4 ☐ Donation 5 ☐ Other (Specify) Signat of F neral Service Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ atherosclerot disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or sella consequence of) If any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pagr 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 NER/Outpatient 3 I DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ycertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier mergencu 29c. License number 29d. Date signed (Month. Day, Year) fort men PHUSICIAY ess of person who completed cause of death (Item 23a) (Type, Print) Burnes Baltimore 3001 m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Year 39 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner nemor Baltimore ナニソ ONION Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F Hours Min. 09/26/196 Maryland 213 90 5604 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c, City, Town or Location Director 1 X Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö must be r Funeral U.S.A. 21230 1904 Wilmington Avenue items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. n "natural", or iten ledical Examiner r 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Technician Drugstore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Kelly Rosa Lee Haynie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21230 1904 Wilmington Avenue Danny Wright / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/11/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory 21. Signature eral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TION C Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death Unknown be detached signed by the Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has page 2 Yes 2 X No 1 Yes 2 Wo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ျှ 1) Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniurv 5 Pending work? 1 ☐ Yes □ Natural death. 17 DEC 10 2 No swe 2100 Accident Investigation all 24 hours after death Funeral Director: completed filled in by the 28f. Location (Street and Number or Rural Route Number, 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 1904 Are Baltimar Wilmina Howe mD 24230 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cadse(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only 29b. Signati 29c. License number 29d. Date signed (Month. Dav. Year) AT 2438946 Vaillai Exic Vaillant, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University Parkway Balto., MD.21218 w

DHMH 17 Rev 7/2009

State Registrar 32. Regis

SATURNO

CASINOFF,

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

'aw Li		artment of Health and Mental F rtificate of Death	Reg. No.				
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year January 1, 2011 3. Time of Death 1415 hrs				
	4a. Facility Name (if not institution, give street and number) 900 S. Beechfield Avenue	4b. City, Town, or Location of Deat Baltimore					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. le	Months Days Hours Min					
μ	Usual Residence of Decedent	Town or Location	3/15/1// Country) & URINIA				
and f show ar	MD B	ALTIMORE	1 Yes 2 No				
With the Maryland with the Maryland to 128 or 28 or 18 or 18 or 18 or 18 or 18 or 18 or 19	10e. Street and Number 900 S BEFCh FIELD 4	10f. Zip Code 11E 21279	10g. Citizen of What Country? BURIN H				
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 23s-fabornastic event, the Medical Examiner must be notified at sonce To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No	Specify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.					
ours afte	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use relations)					
5-0036 led within 72 hour Hygiene. the Medical Exant Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	GENERAL WOL	IKER PRODUCE				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last)	<i>C</i>	e (First, Middle, Maiden Surname)				
MD 2121 12 should be f th and Mental 127 is marked umatic event,	19a. Informant's Name/Relationship (Type, Print) KAW KUNIS -BRO IN LAW		Rural Royte Number, City or Town, State, Zip Code) Rd, BUHMAG, MV Z1239				
of Heal	1 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or, Town, State				
Baltimore, permit. Pages 1 a Department of He Important: If it in injury or other the	4 Donation 5 Other Specify: 21. Signature of Funeral Service Linesee	Action Kid & Com //	oulle FUNETORLEGONE				
Physician	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart proximate Int a Between Onset and				
Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	ol Intoxication	Death Death				
<i>101</i>	Sequentially list conditions, b	*					
amine	cause. Enter Underlying Cause (Disease or injury that initiated						
tO, e be executed ysician and burial - transit	d.		_11 v+				
760, icate be execu physician and the burial - tra	IF FEMALE: 23c. If yes, outcome of pregn		23d. Date of delivery				
certification nding ise as	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	2 Fetal death 3 Ectopic pregna	ancy Month Day Year				
P.O. s that the med by e detache		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
of Vital Records, P.O. Box is Prysician: The law requires that the death offer this certificate has been signed by the attemenal director, page 2 should be detached for un: To Be Completed by Physician:			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?				
tal Recident: The certificate ector, page	25. Was case referred to medical examiner?	26.Place of Death (Check	1 ✓ Yes 2 No 1 ✓ Yes 2 No only one)				
of Vit ling Physic After this of funeral dire	1 ✓ Yes 2 No	ER/Outpatient 3 DOA Other Nursir 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 ✓ Other: Scene 28d. Describe how injury occurred				
c = 1 . ^ ≈ 1 5 1	Pending Investigation 28e. Place of Injury - At hol	fd 1:00pm 1 Yes 2 X No	subject ingested alcohol 28f. Location (Street and Number or Rural Route Number, City or Town, State) 900 S. Beechfield				
Division To the Hospital or Attenwithin 24 hours after death within 24 hours after death completely filled in by the completely filled in by the ledical Certificati	4 Homicide determined (Specify) found	at residence	Baltimore, Md.				
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination an						
To with To con	29b-Sigpeture)and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 2, 2011				
	30. Name and address of person who completed cause of death (Item 2) Victor Weedn MD JD Assistant Medical Examine		ore, MD 21223				
State	31. Date filed (Month, Day, Year). 32. Rigistrar's Signatur						

			Please	Type or Print in Black Indelible Ink		
			For State Registrar	State of Maryland / Department of Ho Certificate of De	loath	ene 0 0 0 3 7
	Physicia Medic		1. Decedent's Name (First, Middle, Las	lee Lewis	2. Date of Death	Day Year 3. Time of Death
	Examin		4a. Facility Name (if not institution, give	street and number) 4b. City, Town, or L Bolice	Location of Death	4c. County of Death
	Funeral Director		220-20-3103	x 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	1	10d. Inside City Limits 1 ☐ Ses 2 ☐ No
	th the Ma 3a or 28; it be notif	ral Dire	10e. Street and Number	10f. Zip Code	2 100	g. Citizen of What Country?
920	e filed within 72 hours after death with the Maryland thal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify:
21215-0036	in 72 hour e. nan "natui e Medical.	Completed by	15. Decedent's Ec (Specify only highest gra Elementary Seconday (0-12)	ducation de completed) College (1-4 or 5+) 16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	uring most of working	Sb. Kind of Business Industry Ch. Paver
	e filed within tal Hygiene. ed other than event, the M	To Be Co	17. Father's Name (First, Middle, Last)	Food Service	18 Mother's Name (First, Middle, Main	-Veteras & Hospita (den Sumame)
Maryland	should by and Mer is mark aumatic		19a. Informant's Name/Relationship (T)	- 11/6- 10-	nd Number or Rural Route Number, Cit	sucrtown, State, Zip Code)
	~ ~		20a. Method of Disposition 1 Burial 2 Cremation 3	QW/S(SON) 5505 KQC 20b Place of Disposition (Name of cemetery, crematory or pringr place)	ady AUE, By	oc. Location - City or Town, State
altimore,	permit. Page Department o Important: If any injury or once.	- 20	4 ☐ Donation 5 ☐ Other (Specification 2) 21. Signature of Funeral Service Licens	varison/letera	NE Company C	Wings Mills, MD
<u>α</u>	ದದ≗ಪ_	2 2	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	USS 4905 Upgo 5 Oblications that caused the death, Do not enter the mode of dying the cause on each line	Jouch as cardiac or respiratory arrest,	Approximate
	Physician Medical	V V	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):		Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate notes in Final Industrial Cause (Disease or linjury	b. Due to (or as a consequence of):		
	oe executed ician and burial-transit	l Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence of):		
3760	ficate be e g physicia as the bur	dedical		d		
. Box 68760	he death certificate be y the attending physic ched for use as the bi	1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	,	23d. Date of delivery Month Day Year
s, P.O.	s tha	þ	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given		cco use contribute to the cause of death?
Division of Vital Records,	law has e 2	Completed			24a. Was an autopsy performe 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
al R	ian: Th		25. Was case referred to medical examiner?	26. Plac	1 ☐ Yes 2 ce of Death (Check only one)	No 1 Yes 2 No
f Vit	Physici this ce ral direc	잍	1 Yes 2 No	Hospital: 1	4 ☐ Nursing Home 5 ☐ Residenc	e 6 Nother (Specify) HOSPice
ion o	tending Paath. tor: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury work? M 1 ☐ Ye	/es 2 □ No	\
Divis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, pag		4 Homicide determined	28e. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)	City or Town, S	
	the Hosp hin 24 ho the Fune mpleted f	Medical	(Check 2 Medical Exami only one) 3 Cartifying Nurs	sician: To the best of my knowledge, death occured at the time, d ner: On the basis of examination and/or investigation, in my opinion, the Practioner: To the best of my knowledge, death occurred at the t	n, death occurred at the time, date and p time, date and place, and due to the cau	place, and due to the cause(s) and manner stated. use(s) and manner as stated.
		_	29b. Signature and title of certifier	29c. License n 200 7	number 29d	Date signed (Month, Day, Year)
	0		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, Print)	wite 4105 Bal	times 21204
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:30 2ÕÏ1 Ам Robert Lee Lewis January 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March Day Year 1929 1 X M 2 □ F Months Days Hours Min Maryland 81 216-24-9592 Director Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1XXYes 2 □ No Marvland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral United States 21212 6119 Bellona Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status "natural", or iten edical Examiner r Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. the transportation sales representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked ot traumatic ever Elizabeth Louise Clarke James Fleming Lewis it. Page 1 and 2 should respondent of Health and Men prortant: If item 27 is marken in injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Radebaugh/daughter Lutherville, MD 21094-4361 P. O. Box 4361 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Jan. 15,2011 4 Donation 5 Other (Specify) Green Mount Crematory per it Der an Imror any inj 21. Signature of Funeral Service License John O. Mitchell IV, Funeral Services of Dulaney Vally, 200 E. Padonia Rd. Timonium, MD 21093 Mitchel 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for L in the past 12 months? Year Month Day Pregnant at time of death g 🗌 Unknown þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signed | 2 should be det Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) |은 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1X Natural work? 5 Pending thin 24 hours after death.

the Funeral Director: Ai ompleted filled in by the fu 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. a Ce i (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) ture and title of certifier 29d. Date signed (Month, Day, Year) D0071187 Name and address of person who completed cause of death (Item 23a) (Type, Print) Lite 4105, Balthware, MD 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ RWOOD M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner toWAR NTY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav) 6. Sex 8. Date of Birth **Funeral** Birthpiac Country) 1 🗆 M 2 📉 Months Days Hours Min (Month, Day, Year) 10-21-1949 Director 236-78-9822 61 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 💢 No MD Anne Arundel Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 20724 United States 70 South Bruce Street 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. f Health and Mental Hygiene. item 27 is marked other than "natural", or i ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Customer Service Retail Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Senate Parsons Wanda Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Thomas D. Leatherwood / spouse 70 South Bruce Street Laurel Maryland 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of P
Important: If ite 5 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State injury o 4 Donation 5 Other (Specify) Arundel Crematory 01-07-2011 Odenton, Maryland 21. Signature of Funeral Service Livense 22. Name and Address of Facility Donaldson Funeral Home & CT 1411 Annapolis Road Odenton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ²² Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical he law equires that the death certificate be Box 68760 the. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cage 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENERAL HOSPITALICOLUMBIAINO HOWARD COONTY 31. Date filed (Month, Day, Year) State Registrar X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 14:45 PM **Physician** AWSON JANUARY 2011 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE BAYUIEW MEDICAL CENTE TOHNS HOPKINS N/A Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min Months Hours 1 □ M 2**X** F 98 Virginia 229-30-9995 10,1912 Aug. Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 'natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Edgemere Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2410 Estelle Avenue United States 21219 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🏖 No If Yes, Give Year or Dates: Specify ģ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other trainment. College (1-4or 5+) Elementary/Secondary (0-12) Avon Products, Inc. Salesperson 6 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Snow Newman Snow 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edgemere, Maryland 21219 2408 Estelle Avenue Mr. Marion J. Lawson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Commation 3 ☐ Removal from State
4 ☐ Donation 3 ☐ Other (Specify) Oak Lawn Cemetery 1/11/2011 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland 23a. P. H. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** /Medical Due to (or as a consequence of) 18 hours Examiner RGANCMULTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy Month in the past 12 months? 5 Other (specify) I □Yes 2 □ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2-17 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000 JANUARY, 07, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MWAKINGWE, M.D. 4940 EASTERN AVE, BATTINIORE AGNES 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

DHMH 17 Rev 1/2001

State

Registrar

JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 4:120 Ам James Larrimore, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lansdowne 403 Bigley Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral May 3, Year 969 1 XM 2 □ F Months Days Hours Min Maryland Yrs Director 213-86-5665 41 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 United States 403 Bigley Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceden 2. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waste Management 12 N/A CDL Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Janet Mints Dennis James Larrimore, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Bigley Ave., Lansdowne, Maryland 21227 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Melissa Lynn Norris/ Friend/POA 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Atlantic Crematory, LL Jan. 1, 2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee AMBROSE AFUNERALITY HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Malignant Cliona Priysician/ disease or condition resulting in death) YELL Medical Due to (or as a printed insequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate by the attending physician and stached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Ves 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1. Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify)

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

(

alu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9103

32. Regist ar's Signature

1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Franklin Squire Drive Suite 2200 BAHTURENE MI)

29c. License number 124356

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 200. Once in any injury or other traumatic event, the Market any injury or other traumatic event, the Market any injury or other traumatic event, the Market any injury or other traumatic event, the Market any injury or other traumatic event, the Market any injury or other traumatic event, the Market any injury or other traumatic event, the Market any injury or other traumatic event, the Market and Market an

For State Registrar

10a. State

Director

by Funeral

Completed

Be ပ

Physician

Examiner

Funeral

Director

/Medical

the Hospital or Attending Physiclan; The law requires that the death certificate be executed

Sequentially list conditions, if any leads to the Cate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		8				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						
a laramouni signinicani condita	ons contributing to death but not resulting in the underlying cause	3	acco use contribute to the cause of death s 2 □ No 3 □ Probably 4 🛣 Unkn				
ted		1 1 10	S 2 NO 3 PIODADIY 4 OIKI				
<u></u>		24a. Was an autopsy	24b. Were autopsy findings avail				
Completed		perform 1 □Yes 2	ed? death?				
25. Was case referred to medical		26. Place of Death (Check only one					
examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 X Nursing Home 5 Resider	nce 6 ☐ Other (Specify)				
27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pendin investig 6 Could determ	g (Month, Day, Year) Injury \	niury at					
3 Suicide 6 Could in determined		ce 28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)				
29a. Certifier 1 Certifyir	g Physician: To the best of my knowledge, death occurred at the Examiner: On the basis of examination and/or investigation, in rand manner stated.						
29b. Signature and title of certifie	29c. Lic	ense number 29	d. Date signed (Month, Day, Year)				
1	D	0054566 J	anuary 5, 2011				
30. Name and address of person Sunitha Bhogav	who completed cause of death (Item 23a) (Type, Print) illi, M.D. 9801 Georgia Aven	ue, Ste. 117, Silve	er Spring, MD 20902				

32. Registrar's Signature

State

31. Date filed (Month, Day, Year)

JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AN YAKU Day Year 10:40AM SHARNA G LEIBOVITZ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Huspital Balt, more N/A 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year 05/28/1933 **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Days Hours Country) Director 212-30-0210 77 Yrs MD Usual Residence of Decedent shov 10a. State 10b. County with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE OWINGS MILLS 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9445 COMMON BROOK ROAD, #203 21117 USA filed within 72 hours after death val al Hygiene. d other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Black, White, etc. ģ 1 ☐ Yes 2 🗓 No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 ACCOUNTS PAYABLE SUPERVISOR FOOD SERVICE Be Department of Health and Mental His Important if Item 27 is marked oth any injury or other traumatter. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEON GROSSMAN MIRIAM BARBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERIE LEIBOVITZ/DAUGHTER 9445 COMMON BROOK ROAD, #203, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS 01/09/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Pad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Congestive disease or condition resulting in death) 1Cars Medical Due to (or as a cons- uence of) **Examiner** Sepsic Month Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) -burialphysician the burial Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Dependent c), abetes Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 A No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death

To the Funeral Director: /
completed filled in by the f М Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number RES-000 MO 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAGLIA Singi MICHAEL M0

DHMH 17 Rev 7/2009

State Registrar

500

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 10t 1015 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 12 kland olumbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) Funeral 217-42-802 1 M 2 M Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Mi ia 1 Yes 2 No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt 72 2104 100 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 2 10 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be . Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည olemar 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Town, State, Zip Code) KO umbra 20b. Place of Disposition (Name of cemetery, crematory or other place, Guilfall Memorus 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 10 4 Donation 5 Other (Specify) Memoria Signature of Funeral Service Licensee House Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ TASTAT disease or condition resulting in death) VINT Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Tary, leading to incrediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 💆 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ြု 4 Nursing Home 5 Besidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending in 24 hours after deau...
the Funeral Director: Aff 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Slanat

State Registrar 6701

32. Registrar's Signature

N CHARLES ST

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MD

Day, Year)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:51 AM Lillian Rose Miceli 2011 Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number Baltimore Kosedale Hospital 8. Date of Birth (Month, Day, Year)
Sept. 27,1926 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M XX F <u>22</u>0-18-3986 84 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f shore event, the Medical Expression must be notified at MD Baltimore Director 1 □Yes 2 No Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 United States 8043 Park Haven Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2x No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2☐No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item In Elementary/Secondary (0-12) College (1-4or 5+) **Plastics** Factory Worker 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Veronica Zawodny Adam Winiecki ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pand Dundalk, Marvland 21222 19a. Informant's Name/Relationship (Type. Print) Thomas J. Miceli (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 1/13/2011 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death)

a. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland **Physician** /Medical Due to (or s a consequence of): Examiner Due (or as a consequence): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, ending physician use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) signed by the a Ö 1 ☐ Yes 2 ☐ No 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 2 **X** No of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ۵ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of the Funeral Director with the funeral director is the funeral director of the funeral director is the funeral director in the funeral director is the funeral director in the funeral director is the funeral director in the funeral director is the funeral director in the funeral director is the funeral director in the funeral director is the funeral director in the funeral director is the function of the funeral director is the function of the function 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 069193 JANUARY, 8, 2011

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

John Kottarathil, M.D.

w & pares

9000 Franklin Square Dr. Baltimore, Maryland 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00326 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** (NMI) 257 PM Michele Magaletta, Jr. 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner altimoa | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 15, 1947 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 033-36-1000 63 Massachusetts Director Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Experiment or notified Director MD 1 □Yes 2 □ No Baltimore Catonsville 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 5 Plateau Ct. 21228 Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. snt: If item 27 is marked other than "naturar", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 XXYes 2 No
If Yes, Give
Year or Dates: Vietnam , or 1 ∏Yes 2 TN No Specify ≥ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director Human Resources Northrop-Grumman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michele Magaletta ٥ Anna David 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tra Denise L. Magaletta (Wife) Plateau Ct., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/10/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Se the. PS/S disease or condition resulting in death) /Medical Due to (or a /a consequence of): Examiner newmon/ Sequentially list conditions, if any, leading to immediate cause. Enter or carning Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of) burial-transi ed by the aftending physician and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: 2 No 1 ☐ Yes 2 Mo 1 ☐Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide

P.O.

ETTA

MAGAL

Box 68760.

Saltimore, Maryland 21215-0036

Division of Vital Records, Hospital or Attending Pl 24 hours after death. Funeral Director: After the 24 hours a To the I within 2

2+1 Registrar

Medical

29c. License number D61829

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Regarlos Avenue, Baltimore MD 21229 900 Caton Lee- [Kear I

31. Date filed (Month, Day, Year) JAN 1 1 2011

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 100 P M Rosa A. Masimore ANUARY 09 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER Social Security Number 8. Date of Birth (Month, Day, Year) NOV . 28 , 1927 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign 1 M 2 T 213-38-6053 83 Director Yrs. Germany Usual Residence of Decedent 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant if item 27 is marked other than "natural", or items 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Lutherville Maryland 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country?
United States items 23a Funeral 1305 Malbay Drive 21093 of America 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. ō à 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify. white Specify: 3 Divorced 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 10 Welder Murray's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Sylvester Waldhutter Bertha Wimmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Earl L. Masimore/ spouse 1305 Malbay Drive Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January permit. Page 1
Department of Important: If it any injury or o once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Dulanev Vallev 14, 2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u>Memorial Gardens</u> 21. Signature of Funeral Service Cense 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Ctr., PA. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or comolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death

/ 204 y Immediate Cause (Final disease or condition resulting in death) nce of): IA VEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying nce of):

Physiciana Medical Examiner

attending physician and I for use as the burial-tran

ed by the detached

been signed the should be det

certificate has b lirector, page 2 s

eral Director: After this certific filled in by the funeral director,

within 24 hours a
To the Funeral C

Medical

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Examiner

Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed To Be 25. Was case referred to medical examiner? 2 No 27. Manner of Death Certificate: Natural
Accident
Suicide
Homicide 5 Pending Investigation Could not be

_ a	SEPSIS
-	Due to (or as a conseque
h -	DEMENT
Б	Due to (or as a conseque

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 23d. Date of delivery Month

24a. Was an autopsy perform

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 2 Yes 26. Place of Death (Check only one)

los	spital: 1 X Inpatient 2 🗆	ER/Outpatient	з 🗆 роа	Other: 4	☐ Nursing H	lome	5 Residence	6 Other (Sp
	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c.	Injury at work?	2 🗆 No	28d.	Describe how inju	ary occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier la

D0059711

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER m.D. DRIVE MARYLAND ADLER TOWSON

State Registrar 31. Date filed (Month, Day, Year) 2011

32. Registrar's Signature ark 11-00099 Anya Marie Myers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible:
State of Manyland / Department of Health and Montal Hydiana

Anya wane my		State of Maryland / L 1-For State Registrar	Certificate o			2011 Reg. No.	00328				
Physic Medical Exam		1. Decedent's Name (First, Middle,Last)			2. Date of De Month	Day Year	3. Time of Death 1549 hrs				
		Anya Marie Meyers 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	January eath	4c. County of Deat						
		Baltimore Washington Medical Center	Glen Burnie		Anne Arunde						
Funeral Director			n yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Min	Birth (MM/DD/YYYY) 9. Bi	gn				
		214-21-6503	22 Yrs		07/2	0/1988 c	ountry) MD				
, any			c. City, Town or Locat	ion			10d. Inside City Limits				
land rshow	ō	Maryland Anne Arundel		Pasade	na		1 Yes 2 X No				
7498 the Marylanc	Director	10e. Street and Number		10f. Zip Code	Ï	10g, Citizen of What Cou	ntry?				
THE 8	a D	7905 Wiltshire Court 11 Marital Status 12 Was Decedent Eve	er in ILS 13 Wa	21122 s Decedent of Hispanic Origin?	/ Specify Vac or N	USA	ican Indian, Black,				
ieath v r item	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X	If Y	es, specify Cuban, Mexican, Pu		White, etc.	ican indian, black,				
after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No specify:		Specify: Wh	ite				
hours "natur	ted	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+)		t's Usual Occupation (Give kind ost of working life. DO NOT use		16b. Kind of Business/	Industry				
D36 thin 72 ne.	Completed	9		Student		Educ	ation				
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medical		17. Father's Name (First, Middle, Last)			ame (First, Middle,	Maiden Surname)					
2121 Id be f Aental narke event,	o Be	Charles A. Meyers 19a. Informant's Name/Relationship (Type, Print)	10h Mailine	Kimb Address (Street and Number		Brewis					
	ř	Charles A. Meyers (father	- 1	Wiltshire Cour							
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition		ition (Name of cemetery,	Date	20c. Location - City or					
Baltimore, permit. Pages I are Department of Hee Important: If iten injury or other tr.				matory Inc.	2011	Baltimore	, Maryland				
Balt ermit. Departumportumportum		21. Signature of Funeral Service Licensee	22. N	ame and Address of Facility		ngs Funeral	Home, P.A.				
Physician		23a. Part I. Enter the disease, or complications that caused the	death. Do not enter th	3111 Mountair	Road, P	asadena, MD	21122 Approximate Interval				
- Medical	2005	failure. List only one cause on each life.) Intoxication			Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a conseque	nce of);								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	ince of):								
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated									
uted nd ransit	Ex	events resulting in death) Last Due to (or as a conseque d.	rice or):								
(68760, certificate be executed anding physician and ise as the burial - transit	Medical	x UNPENDED 23a,	27,28a-f	per me g912 2- 2-7-11 vt	4-11 vt						
lox 68760, leath certificate be exe e attending physician a for use as the burial -	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of	f pregnancy	1000		23d. Date of delivery					
	icia	past 12 months?	of death	al death 3Ectopic pre er (Specify)	gnancy	Month D	ay Year				
BOX he death cy the attenty thed for us	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown			la si						
, P.O. B ires that the d signed by the	虿	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Part I.		obacco use contribute to to s	ć===				
ords, w require s been si	eted					an 24b. Were aut	opsy findings available				
ecol ne law te has l	Completed					rmed? death?	ompletion of cause of				
Division of Vital Records, P.O. Box the Hospital or Atteoding Physician: The law requires that the death him 24 hours after death. the Funeral Director: After this certificate has been signed by the atterphetely filled in by the funeral director, page 2 should be detached for a	Be	25. Was case referred to medical		26.Place of Death (Che		2 No 1 ✔ Ye	s 2 No				
F Viti	10 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of In		sing Home 5						
on of Vi oding Physith. The After this	how injury occurred										
Division tal or Atteodi rs after death.	ficat	Pending Investigation Suicide Suicide Suicide Suicide Suicide Pending Investigation Fd 1-3-11 28e. Place of Injury	Fd 3:03	1 Yes 2 No , factory, office building, etc.	unknow 28f. Location (al Route Number, City				
Divisipital or At ours after deral Direct filled in by	Certification:	determined	idence		or Town, S Pasaden	Street and Number or Run State) 7905 Wil a, Md. 2112	tshire Ct. 2				
Division To the Hospital or Atteod within 24 hours after death To the Funeral Director: completely filled in by the		1 29a. Certifier									
To the within To the comp	Medical	one) 2 Medical Examiner: On the basis of examinat and manner stated. 29b Signature and title of certifier	and/or investigate	29c. License number	u at the time, date	and place, and due to the 29d. Date signed (Mon					
		TO 1 11 1 1-1	7	O.C.M.E.	OCME	January 4, 2011	ur, Day, rear)				
	ŀ	30. Name and address of person who completed cluse of death	(Item 23a)								
				00 W. Baltimore Street,	Baltimore, MI	21223					
St	ate	31. Date filed.(Month, Day Year) 32. Registrar's Sig	gnature	and the same of th							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Edmond J. McDonnell, M.D. 7:15 P M 2011 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2020 Stockton Rd. Phoenix Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28 1916 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 □ F **Director** 151-07-6260 94 N.J Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shor Director 1 ☐ Yes 2 👿 No MD Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2020 Stockton Rd. 21131 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after Armed Folces: 17 Yes 2 No If Yes, Give Year or Dates: 43-46 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: by white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Orthopedic Surgeon Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi th and Mental H Peter McDonnell Elizabeth Toole 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 is any injury or other trau Mrs. Isabel C. McDonnell/wife 2020 Stockton Rd., Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 1/8/11 Baltimore, MD 21. Signature of Funeral Service Lisense 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Rd., Timonium, MD 23a. Part 1. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SUDDION C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown ò signed if Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DOK 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performe certificate 1 ☐ Yes 2 ☑ No director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural death. after death

Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dil completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 29b. Signatu title of certi 29c. License number 29d. Date signed (Month, Day, Year)

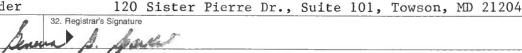
State / Registrar

DHMH 17 Rev 1/2001

State 31. Date filed (Month, I

31. Date filed (Month, Day, Year)

Jeff Alexander



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

44560

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia M. McNicholas Jahuary 2011 10:04 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/AKeswick Multicare Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 👿 F Months Days Hours Min AMP 17 Day 1 Year 1929 217-24-6509 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must hand any once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 N/A **Baltimore** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 700 W. 40th Street 21211 LISA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Private Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Gertrude Moore George Carrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 W. 42nd Street, Baltimore, Maryland 21211 Thomas W. McNicholas, Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burja 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Moreland Memorial Park 1/8/2011 Parkville, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Service Dice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final acuse repal facione Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Aintenna week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 1 weeks Klebsieller Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and a betached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ mounds 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed cardiavaventar disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed After this certificate 2 🔲 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death heck only one) examiner? ဂ 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 24 hours after death Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tanuary 6,2011 N Babelle D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE REPORT, 700 W 40 th STREET, BALTITORE, 510 21211

DHMH 17 Rev 7/2009

State Registrar 32. Registrate Signa

11-00177 Alan Gilmore Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	tate of Maryland			Death	G MEN		Reg. No.	JII	0000	
Physici		Decedent's Name (First, Midd						2. Date of De	eath	Year	3. Time of Death	
Medical Exam	iner Alan Gilmore Miller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death										0235 hrs	
		1409 Valley Forge Wa	Death	4c. Cour Harfo	nty of Death rd	1						
Funeral		Social Security Number		ge (In vrs. last b	irthday)	Abingdon If Under 1 Year	r I If Under	24Hrs. 8. Date of F			tholace (State or	
Director		543-32-9162	3-32-9162 1XM 2F 79 Yrs. Months Days Hours Min. Apr. 3, 1931 Foreign									
		Usual Residence of Decedent						1.51.	3/ 1/31			
w any		10a. State 10b. County		10c. City, Tow	n or Location	on					10d. Inside City Limits	
Maryland 28a-f show d at once.	ğ	Maryland Har	ford	Abin	gdon						1 Yes 2 XNo	
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
ith the 23a o	a D	1409 Valley E		4 Francis II C	140 144-	21009		2/2 / 2/	USA			
ath w items	Funeral	1 Never Married 2 X M	12. Was Deceden Armed Forces	?				n? (Specify Yes or No Puerto Rican, etc.)		ace - Ameri /hite, etc.	ican Indian, Black,	
fter de		3 Widowed 4 Div	orced If Yes, Give Year	No No	1	Yes 2 No	specify:		Specii	r∵ Whi	+0	
2 hours aft "natural"	d by	15. Decedent's Education (Spe	ocify only highest grade co	mpleted) 16a	Decedent	's Usual Occupati	ion (Give kir		16b. Kind of	_		
36 thin 72 hore. than "no edical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo	ost of working life.	DO NOT us	se retired)				
withir iene.	ᇤ		7+		Phy	sician				hiatr	<u>Y</u>	
15-1 filed al Hyg ed oth	Be C	17. Father's Name (First, Middle,]1		Name (First, Middle		,		
21215-00 uld be filed wit Mental Hygien marked other	To B	Horace Gilmore 19a. Informant's Name/Relations		11	9b. Mailing	Address (Street		tasia Ben er or Rural Route No			Zin Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other fraumatic event, the Medical Examiner must be notified at once		Marilyn J. Mil	ller/ Wife	1				Way, Abi				
e, e, l and l and Healt		20a. Method of Disposition			of Disposit	tion (Name of cen	netery,	Date			Town, State	
Pages ent of		1 Burial 2 Cremation 4 Donation 5 Other St		late	•		om.	1-11-11	TOWS	on M	aryland	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	М	21. Signature of Funeral Service						Home, P.	7	0117 11	dryrana	
0 5045	(()	Steples (1	Mugh		113.	17 Cokesi	burv 1	Rd. Abin	adon. M	D 210	09	
Physician Wasical		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused on each line.	the death. Do r	ot enter the	e mode of dying,	such as care	diac or respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and	
Examiner	1	Immediate Cause (Final disease or condition resulting in death)			ar Disea	se					Death	
			Due to (or as a cons b.	equence of):								
	je	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):								
	Examine	rausa Enter Underlying Gauss (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):			-					
secuted ransit		events resulting in death) Last	d.									
60, ate be executed hysician and e burial - transi	Medical	UNPENDED	AMENDED									
760 icate b		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome	me of pregnancy					23d. Date	of delivery		
ox 687 eath certific attending p	clan	past 12 months?	I TIAG DIGIT	Attack of standards		al death 3 er <i>(Specify)</i>	Ectopic p	regnancy	Month	D	ay Year	
Box death he atte	Physician/	1 Yes 2 No 9 Unk	known 9 Unknown		⊃ Oth	er (Specify)	******					
at the etache	by Pt	Part II. Other significant conditi	ions contributing to deat	h but not resultir	ng in the un	derlying cause gi	ven in Part	I. 23e. Did	tobacco use cor	ntribute to t	the cause of death?	
S, P.C nires that n signed b d be deta								1 Ye	es 2 No	3 Proba	ably 4 🗹 Unknown	
ord:	Bet							24a. Was auto	psy		topsy findings available ompletion of cause of	
Rec The la	Completed							perfo 1 ✓ Yes	ormed? 2 No	death? 1 ✓ Yes	s 2 No	
tal E	BB	25. Was case referred to medical examiner?	Hasnital:)4h-a-	heck only one)				
F VI Physical circles	리	1 Yes 2 No 27. Manner of Death	i inpatie		Outpatient Time of Inj		Other ₄ N	lursing Home 5	Residence 6		Scene	
ading th.	<u>Ë</u>	1 ✓ Natural 5 Pend	28a. Date of Inju (Month, Day, Y	'ear)	Time of Inj	· I — ·	es 2 N		how injury occu	irea		
isic After er dear rector	igat	2 Accident Inves	stigation 28e Place of In	njury - At home, f	arm, street.	, factory, office bu			Street and Nun	nber or Rur	al Route Number, City	
Div pital or ours aft filled ir	Certification:		d not be (Specify)			•		or Town,			arrivate Hamber, Only	
		29a Cortifier	nysician: To the best of m	y knowledge, de	ath occurre	ed at the time, dat	e and place	, and due to the cau	se(s) and mann	er as state	d.	
To the Howithin 24 h To the Fu	Medical	one) 2 Medical Exar	miner:On the basis of exa and manner stated.	mination and/or	investigatio	on, in my opinion,	death occur	rred at the time, date	and place, and	due to the	cause(s)	
	Σ	29b. Signature and title of certifie				29c. License			29d. Date sig	ned (Mon	th, Day, Year)	
		Yanula Frun	hallins			O.C.N	1.E.		January 6	3, 2011		
2041		30. Name and address of person Pamela E. Southall, M		. ,	r 000	M Rallinar	Street 5	Caltimore ME C	1222			
	ate	31. Date filed (Month, Day, Year)		r's Signature	. 900	vv. baitimore	otreet, E	bailimore, MD 2	1223			
Regist		JAN 1 1 2011	Beneva 1	1. par	Ked							
DHMH 17 Rev 1/20	001	<u>-</u>	201	05	DIGINAL			245				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year January 2011 6:30 PM Charles Medical Richard Mainhart 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death <u>Charlotte Hall Veterans Home</u> Charlotte Hall Saint Marys 8. Date of Birth . Age (In vrs. last birthday If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1**X**] M 2 □ F Months Days Hours Min 5/15/1934 **Director** Pennsylvania 170-26-5402 76 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State at 10c, City, Town or Location within 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2X No Maryland Saint Marys Charlotte Hall 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Route Salesman Bakery 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. <u>Carl Joseph Mainhart</u> Geraldine Curley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Mainhart (Son) Stevenson Lane Towson, Maryland 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Gardens of Faith Cem. Overlea, Maryland Figure of Fune Al Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es Maryland 21221 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical esulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 T Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an is certificate has be director, page 2 s autopsy performed? Yes 2 XN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) s after death.

al Director: After this ce Hospital Other: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural iniury 5 Pending work?
1 Yes 2 No Investigation Accident 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours af Funeral Dieted filled in 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

completed only one) 29c. License number 46046 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 2011 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amir Alikhani, M.D., 101 Centennial St., La Plata, Md. Mirza 2. Registrar's Signature State parks

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <u>0</u> 9 Day Physician/ Month 01 2011 0813 Corrine Monroe-Maddox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilcrest Hospice Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🛛 F Min 0677371948 Maryland 62 Yrs Director |219**–**50–3360 Usual Residence of Decedent Show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits at with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 XYes 2 No N/A Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 3407 Bateman Ave. 21216 U.S.A. Page 1 and 2 should be filed within 72 hours after death upent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify. Specify: 3 Widowed 4 Divorced Black Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Transit Authority Operator-Light Rail Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Monroe Doris Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Maddox(husband) 3407 Bateman Ave., Baltimore, MD 21216 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/03/11 Baltimore, MD Address of Facility

Hulbrow
Fulton 21. Signature of Euneral Service Licenses 2725eph nyfr; Baltimore, MD 27217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) by the attending physician and stached for use as the burial-transit Gause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy has e Hospital or Attending Physician: The L 24 hours after death. e Funeral Director: After this certificate h 2 🗌 No 1 Yes Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: Hospice 1 Yes 2X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work? 1X Natural 2 🗌 No M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly one 29h ianatu title of certifier 29d. Date signed (Month, Day, Year) 10/11 DOOTI

DHMH 17 Rev 7/2009

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Januar' 2:57 Julia Meadows Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Year) 1<u>928</u> 1 D M 2 K F Days Min. Hours Sept 28 Country) Maryland Director 215-40-9232 Vrs 82 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Maryland 1 😾 Yes 2 🗌 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5029 Gwynn Oaks Avenue 21207 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify "natural", Completed 3 X Widowed 4 □ Divorced ^{Specify:}African—Americar Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress Restaurant Be . age 1 and 2 should be filed. Should be filed of health and Mental Herbrath in the street any injury or other space. 17. Father's Name (First, Middle, Last) (unk) 18. Mother's Name (First, Middle, Maiden Surname) (unk) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Desiree D. Powell/great-neice 4387 Eagle Court Waldorf, Maryland 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Final Journey Crematory 1/13/2011 Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 20100 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as th 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnan 23d. Date of delivery in the past 12 month Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 0 Mores 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has performed Yes 2 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 11 NA 1 Yes မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction in To the best of my knowledge death occurred at the time, date and place, and due to the cause(c) and manner as etaled. (Check 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rober

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

P

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once.

Physician

Examiner

Funeral

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

P.O. Box

Division of Vital Records,

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

/Medical

10a. State

Directo

Funeral

≥

Completed

Be

ner Exami page 2 should

physician and the burial-transit Physician/Medical attending ph n signed by the a \$ Completed peen certificate has Be After this Certification: To To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 Unknown

25. Was case referred to medical

examiner?

27. Manner of Death

1 1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

Medical

1 XYes 2 ☐ No

1 ☐Yes 2K No 1 ☐ Yes

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

Ylanas

determined

29c. License number 0101056273 VA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) January 6, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy Baxi, M.D. 6900 Georgia Avenue, NW Washington, D.C. 20307

nu

State Registrar

15

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Olender Jänuary 7:47 A M 10, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Dundalk 1505 Leslie Road Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 💢 M 2 🗆 F Months Hours 74 January 30, 1936 WashingtonD.C. **Director** 218-32-2158 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start: If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dundalk 1 Yes 2 X No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 Leslie Road 21222 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify.White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 9 yrs. College (1-4 or 5+) Mechanic Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen Olender Anna Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Olender 1505 Leslie Road, Dundalk, Maryland wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Sacred Heart of Jesus 13, 2011 Dundalk, Maryland 21. Signature of June al Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death METASTATIC GASTRIC CANCER Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE CORONARY ARTERY Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 🗌 Yes 2 🗆 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 😿 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR 1 064931 JANUARY, 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIS COSGROVE, 600 NORTH WOLFE STREET, BALTIMORE, MS 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2011 backs Registrar

11-00261 Dottie Player Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ottle Player		1- For State Ce.	artment of Health and Mental H <i>rtificate of Death</i>	Reg. No.						
Physic Medical Exam		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year						
Hedical Exam	IIIGI	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January 3, 2011						
Funeral		4700 Post Road 5. Social Security Number 6. Sex 7. Age (In yrs. I	Baltimore last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or						
Director		219-66-7397 10M 20F	53 Yrs. Months Days Hours Min	- I Familia						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City.	, Town or Location	10d. Inside City Limits						
Maryland 28a-f show d at once.	tor	10e. Street and Number	Kathmae 10f. Zip Code	1 10g. Citizen of What Country?						
h the Mai 3a or 28	Director	4700 Post Rd	21215	US.A						
leath with	Funeral	11. Marital Status 1	.S. 13. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.						
2 hours after d "natural", or	J. Y.	3 Widowed 4 Divorced or Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify:	Specify: Black						
	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti							
5-0036 ed within 7; tygiene. other than	Som	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)						
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	To Be	Knight Player 19a Informant's Name/Relationship (Type, Print)		Amina Miles Rural Route Number, City or Town, State, Zip Code)						
ore, MD 2121 (set 1 and 2 should be fil of Health and Mental H If item 27 is marked her traumatic event, 1	٦	Janice Player	13816 Cottage Av	Le, Baltimore, MD						
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.		1 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cernetery, crematory or other place)	Date 20c. Location - City or Town, State						
Baltimore, permit. Pages I as Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	22. Name and Address of Facility	13/2011 Baltimore, MU						
の ^製 る見頭 Physician	-	23a. Part I. Enter the disease, or complications that caused the death.	. 4650 hiberty	Heights Aree, Balto NO						
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Colon Cancer		Between Onset and Death						
		or condition resulting in death) Due to (or as a consequence of Sequentially list conditions,	<i>l</i>):							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Jisease or injury that initiated	n:							
uted nd ransit										
60, ate be executed hysician and te burial - transit	Wedical	UNPENDED AMENDED		A						
Sox 6876 death certificate e attending phy for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr	2 Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month Day Year						
Box e death c the atten ed for us	hysic	1 Yes 2 No 9 V Unknown 9 Unknown	other (specify)	5						
P.O.	by P	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown						
Vital Records, hysician: The law require this certificate has been si I director, page 2 should b	Completed			24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of						
ital Recition: The Ist certificate h	Com	25. Was case referred to medical	26.Place of Death (Check of	performed? 1 Yes 2 No 1 Yes 2 No						
Vita hysician this cer	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nursing	g Home 5 Residence 6 🗹 Other: Scene						
On of ending P ath. or: After he funer		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred						
Division To the Hospital or Attenwihin 24 hours after death To the Funeral Director:	Certification:	Suicide Could not be determined (Specify)	on 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)							
Hospit. 124 hour Funera		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only)								
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination ar and manner stated. 29b. Signature and title of certifier	nd/or investigation, in my opinion, death occurred at 29c. License number	t the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)						
		Pumet Pruthall MA	O.C.M.E.	January 10, 2011						
		30. Name and address of person who completed cause of death (Item Pamela E. Southall, MD Assistant Medical Exar	· ·	more, MD 21223						
S Regis	tate	31. Date filed (Month Pariyear) 32. Registrar's Signatur	re							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20^{Year} Thomas Eugene Poe 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. January Country) Maryland 220-26-6776 85 1946 Director Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Calvert 1 Yes 2xtx No MD Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 831 Golden West Way 20657 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 XXIo Specify: Specify: Completed XX Widowed 4 Divorced 1953 Year or Dates White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Grade 12 Carpenter Home Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Mary Caroline Gore Thomas C. Poe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Diane Marstaller /daughte Box 827 Solomans, Maryland 20688 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XX remation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 1/10/2011 Odenton, Maryland 21. Signature of Funeral Service Licensee 2Donaidson funeral Home, P.A. M00770 Talbott Avenue Laurel 23a. Part 1. Enter the disea se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure List only one cause on each line Immediate Cause (Final da Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) tending physician a r use as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t lirector, page 2 s autopsy perform 1 Ves 2 XV 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) 1 Yes 2 No 은 1 Inpatient 2 KER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier within 24 hou

To the Fune

completed fi (Check 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 005224 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph John Barth, III, 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:30 AM January 10, 2011 Elsie Gyles Pettebone /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Tate Chesapeake Hospice House Anne Arundel Linthicum 1 Year | If Under 24 Hrs. If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 6. Sex Days Hours Months Min. 1 □ M 2 🗓 F Yrs. 212-42-7384 Director 86 09-16-1924 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "material" any injury or other than "material". 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗓 No Directo Anne Arundel 0denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7649 Milk Glass Court Funeral 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2X No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Anne Arundel County Government Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Ronald Corbin Gyles Valeria Still 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7649 Milk Glass Court Odenton, Maryland 21113 John E. Pettebone / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State South 4 ☐ Donation 5 ☐ Other (Specify) Blackville Cemetery 01-17-2011 Blackville, Carolina 22. Name and Address of Facility 21. Signature of Funeral Service Licens Will Erbourk Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that closed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bladder (aranoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 Dother (Specify) examiner' Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Route Number, City or Town, State) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Husy,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1

31. Date filed (Month, Day, Year)

601

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Of Maryland Registrar	/ Department of Health and M Certificate of Death	Reg. No.2011 0034						
hysician /Medical	1. Decedent's Name (First, Middle, Last)	Pecora	2. Date of Death Month Day Year January 06 2011 01:00 A						
xaminer	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last	4b. City, Town, or Location of Death Baltimore City t birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	4c. County of Death N/A 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Forei Country)						
ector	220-05-5276	Yrs. World's Days Hours Will.	(Month, Day Year) Oct.17,1914 North Caroli						
d at Or		Town or Location Dundal	10d. Inside City Lim 1 ☐ Yes 2 🗓						
or 28a-f st e notified a Director	10e. Street and Number	10f. Zip-Code	10g. Citizen of What Country?						
s 23a c nust be		21222	United States						
n", or items 23a xaminer must b by Funeral	f Yes, Give 3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify: 	acify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White						
or other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Barber	ing 16b. Kind of Business/Industry						
	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname) DeLuca						
If Item 27 Is marke or other traumatic			al Route Number, City or Town, State, Zip Code) 1k, Maryland 21222						
t: If item y or othe	To banks E continued to the most state	netery, crematory or other place)	Date 20c. Location - City or Town, State						
Important: If any injury or once.	21. Signature of Funeral Service Densee		D/2011 Baltimore, Maryla Home of Dundalk, Inc. ndalk, Maryland 21222						
physician and second is the burist-transit and legical Examiner		m organ failure nce of):	or respiratory arrest, Approximate Interval Between Onset and Death						
should be detached for use as the letted by Physician/Med		eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year						
signed by Id be detaid	Part II. Other significant conditions contributing to death but not result	23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown							
page 2	24a. Was an autopsy prior to comple death? 1 Yes 2 No 1 Yes 2								
al director,	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury 2	R/Outpatient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred						
led in by the funer Certification:	1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 6 Could not be determined 4 Homicide 6 Could not be building, etc. (Specify) Injury Work? M 1 Yes 2 No 286. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 287. Location (Street and Number or Rura City or Town, State)								
completely filled in t	29a. Certifier 1 Certifying Physician: To the best of my knowle (check only one) 2 Medical Examiner: On the basis of examination and manner stated.		and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)						
0 = 0	29b. Signature and the of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
comple	I I A A II		1988						
comple	30. Name and address of person who completed cause of death (Item 2	RES - 000	January 06 2011						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day 2011 Physician/ January 6, Victor John Pleskacz 10:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Services-Rossville Rossville Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 ₩ M 2 □ F 201-12-2019 09/17/1924 Pennsylvania Director 86 Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7955 Wynbrook Road 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give þ 1X Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed Specify: 3 Widowed 4 Divorced white WWII Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Aero Space Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Pleskacz Frances Bukowinska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 East Kings Hiway # 116 Maple Shade, NJ 08052 Linda J. Gubenski (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/8/2011 Baltimore, Maryland Bayview Crematory Inc: 21. Sigi of Euneral Service Licer 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part nter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shoc heart failure. List Immediate Juse (Final Physician/ Prinomy disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The 24 hours after death. 1 Yes 2 No Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 🌠 No ျ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- SWITT 308

Atugain mo

N-GUAN ST

32. Registrar's ignatur

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 00343 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Doris Phenicie Leverne January 8 3:25 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 431 Taney Drive Taneytown Carroll Social Security Number . Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 30, 1921 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min **Director** 217-18-2832 89 Maryland Usual Residence of Decedent Show at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f st notified 1 Yes 2 XNo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 205 Hillcrest Road 21122 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 XNo Specify: "natural", Specify: 3 Widowed 4X Divorced Year or Dates. White event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Cummins Gladys or other traumatic Haines and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Shawn Jeannette Qualls/daughter 431 Taney Drive Taneytown, Maryland 21787 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/12/2011 Woodbine, Maryland ire of Funeral Service Lic Coing home Cremation Service P.O. Box 784 M00957 iomad Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final ounces Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or rinjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Completed 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) daughter Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\begin{align*}\overline{\text{Other}}\) Other (Specify) 2 X No ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Investigation Accident within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or invention to Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifled 29c. License number 29d. Date signed (Month, Day, Year) D39505 Kan_MD 20

State

Dr. Glen Burnie.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yodhrih Markom, 305 Hospi Hol

32. Regist ar's Signature

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.												
		State of Maryland / Department of Health and Mental Hygiene										00344	
	1. Decedent's Name (First, Middle, Last) 2. Date of Physician/ Granville Edward Paules III Japun									2. Date of De Januar	ath		3. Time of Death
	Medi Examir		4a. Facility Name (if not institution	n, give street and number)		raur	4b. City, Town,	or Location o	of Death	Januar		. County of Deat	9:30 PM
	-		Shady Grove Ad 5. Social Security Number		ital ge (In yrs. las	et hirthday)	If Under 1 Yea	Rockvi		8. Date of Bir	**	Montgon	
	Funeral Director		449-50-6901	1 X M 2 □ F	73	Yrs.	Months Days		Min.	March 2	2^{Year}	937 Peni	thplace (State or Foreign untry) nsylvania
	and show dat	ō	Usual Residence of Decedent 10a. State 10b. County	у	10c. City,	Town or Loc	cation	- .					10d. Inside City Limits
	Maryl 28a-f notified	irect		gomery		Rocky							1 🏋 Yes 2 □ No
	with the 23a or st be r	Funeral Director	10e. Street and Number 19 Harvard Co	urt			10f. Zip Code	350			_	tizen of What Co ted Stat	-
	death y		11. Marital Status	12. Was Decedent Armed Forces	7 104	13. V	Vas Decedent of Yes, specify Cul		gin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White	rican Indian,
980	rs after ral", or Exami	Completed by	1 ☐ Never Married 2 💢 Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 X Yes 2	No 190 199	,	☐ Yes 2 💢 N					0 "	nite
21215-0036	72 hour n "natu ledical	nplet		ent's Education lest grade completed)	I	(Give k	ent's Usual Occu	during most	of working	g	16b. F	Kind of Business	Industry
212	within giene. er thar the N	Con	Elementary/Seconday (0-12)	College (1-4 or 5+	5+)		ONOT use retired ems Eng:	•			NA	ASA	
and	ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Granville Edwa	,	Tω					(First, Middle,		Surname)	
Maryland	hould band Mers mark	ľ	19a. Informant's Name/Relations		JI.	19b. Mailin	g Address (Stree			Route Numbe		r Town, State, Zij	o Code)
Ž.	and 2 sl lealth a sm 27 is		Diane L. Paul	es / Wife		19 Ha	rvard Co					yland 20	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy finity or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (3 Removal from Stat	cei	metery, crem	sition (Name of patory or other pla crematori u	J		ry 10,		ocation - City or	Town, State Maryland
saftir	permit. P Departm Importar any injur		21. Signature of Funer & Service	Licensee					20 Funer				
	205 20		23a. Payt 1. Exter the disease, of	11/1/1/	01305	Do not ente	West Mon	ntgomery	Aven	ue, Rock	ville	e, Marylar	nc. nd 20850-2805
	nysician/	6 (shock, of heart failure. List Immediate Cause (Final	only one cause on each lin	ne.	1		XVVES	,	respiratory an	rest,	18	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as	a conse lue		1	707					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Ben-	10 5 a conseque	hodence of):							
Np.	e executed cian and urial-transit	Examiner	Cause (Disease or linjury that initiated events	c. jye		phriti	5						
	be exe	ical E	resulting in death) Last	Due to (or as	s a conseque	ince oi):							
9289	rtificate be ing physici e as the bu	/Med	IF FEMALE:									İ	
Box 68760	eath certifica attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	2 Fetal	death 3	Ectopic pregnar Other (specify)	ісу			Î	23d. Date of del Month	ivery Day Year
P.O. B	It the dea	Phys	9 Unknown	9 Unknown				in a Book I					
s, P.	lires that signed Id be der	Completed by	Part II. Other significant conditi	ons contributing to death	but flot resul	ung in the di	idenying cause g	iven in Fart i.					the cause of death?
of Vital Records,	law require has been si le 2 should	plete								24a. Was			topsy findings available completion of cause of
Re	ician: The la certificate ha ector, page									perfo	rmed? 2 X N	death?	2 No
Vita	lysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 🗆 E	:B/Outpatient	Ot	Place of Death			danca G	Other (Spec	56 A
l of	ing Phys (fter this uneral di		27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of inj	ury 2	8b. Time of injury	28c. Inju	ry at k?	28	8d. Describe h			iry)
Division	Attendir r death. cctor: Af by the fu	Certificate:	2 Accident Investi	igation not be	jury - At hom	ne, farm, stre		Yes 2	-	8f. Location (S	Street an	d Number or Bur	ral Route Number,
ON CO CO CO CO CO CO CO CO CO CO CO CO CO									n, State,)			
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical I	g Physician: To the best of Examiner: On the basis of g Nursia Practioner: To the	f my knowled examination a	dge, death o	ccured at the tim gation, in my opin	e, date and p ion, death occ	olace, and curred at t	due to the car he time, date a	use(s) ar nd place	nd manner as sta , and due to the o	ted. cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifie	r	Joseph Drings	110 HA 100 Str. 101	29c. Licens	se number		are oue to the	29d. Da	te signed (Month	, Day, Year)
	1400		onfy the	o m.o.	dab ## -	NO-1/75	700	455 0	55		Jan	vary 51	2011
11	2		30. Name and address of person Giufang Chen	wno completed cause of a MD 9901	Medic	(Type, Pr	nter Dr	ive	Rock	ville,	И	an land	20850
	Stat Registra	te ar	31. Date filed (M + th, Day, Year)	32. Registr	ar' Signatu	and	,						ause(s) and manner stated. stated. Day, Year) C 1 (2085

2130

JANYARY 4, 2011

CRANVILLE FOURTO PANCES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03 Walter Raymond Price, Jr. JANUARY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE N/A AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 213 24 5719 80 Maryland **Director** 08/23/1930 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Anne Arundel Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Brian Street Funeral 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No Specify: δ Specify: 3 Widowed 4 Divorced and Mental Hygiene.

Is marked other than "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pressman II th American Can Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Raymond Price Sr. Virginia Marie Harper ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Mary Price / Wife 610 Brian Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01/10/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signal of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days airnau **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leauning to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ syndrom & 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗆 No 1 □ Yes 2 **□**No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of After this . Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Records.

Vital

NALL

U

Sal

Registrar

900 CATON AVENUE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL ROSALES

31. Date filed (Month, Day, Year)

JAN 1 1 2011

, 7011

BALTIMORE, MD 21229

11-00132 Stanley Price Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.											
Physici	an/		Decedent's Name (First, Middle,Last) 2. Date of Death								3. Time of Death		
Medical Exam	iner											1526 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
		Maryland General Ho	Maryland General Hospital Baltimore								N/A	7	
Funeral		5. Social Security Number	6. Sex	7. Age (Ir	yrs. last birt		nder 1 Year	If Under		. Date of Birt	h(MM/DD/YYYY	9. Birth Foreign	
Director		215-86-3198	1 X M 2	F	47	Yrs.	onths Days	Hours	Min.	07/18	3/1963		intry) MD
		Usual Residence of Decedent			7/			<u> </u>			· · · · · · · · · · · · · · · · · · ·		
any		10a. State 10b. County	,	100	. City, Town	or Location							10d. Inside City Limits
ryland a-f show it once.	ř	MD N	/A			Bal	timor	e				ł	1 X Yes 2 No
aryla 3a-f ator	ectc	10e. Street and Number		-		10f.	Zip Code		-	10	g. Citizen of Wh	at Coun	try?
he M 1 or 2 iffed	Director	2809 W. Mulb	erry St	_			212	223			U.S.	Α.	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		Decedent Eve	r in U.S.	13. Was Dec			n? (Specif	y Yes or No-			can Indian, Black,
eath item	rue	1 Never Married 2 N	Married Arme	d Forces?	No	If Yes, sp	ecify Cuban,	Mexican, F	Puerto Rica	an, etc.)	White	, etc.	
fter d	F	3 Widowed 4 Di	vorced If Yes, Give		NO	1 Yes	2X No	specify:			Specify:	B1	ack
urs a fura	d by	15. Decedent's Education (Spe	ecify only highest	grade complet		ecedent's Usi				done	16b. Kind of Bus		
)36 thin 72 ho re. than "ua edical Ex	ete	Elementary/Secondary (0-12)	Colleg	e (1-4 or 5+)	─	luring most of	working life. I	DO NOT u	se retired)				
-0036 d within giene. ther that	du		3 ye	ears		Entre	prene	eur			Self-	Em	ployed
15-00 iled wi Hygier d other	Completed	17. Father's Name (First, Middle					14	8.Mother's	Name (Fir	st, Middle, M	laiden Surname)		
:121 Id be fill fental F anrked event, i	Be	Stanley Paul	Price	Sr.				Rosa	a Whe	eeler			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	2	19a. Informant's Name/Relation	ship (Type, Print)								ber, City or Town		
MD d 2 sh th an a 27 i		Rosa Wheeler	(mother	r)							timore		
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic		20a. Method of Disposition 1 Burial 2 X Crematio	a 2 🗆 Barray			f Disposition (I			Da	ate	20c. Location -	City or T	own, State
TO ages		1 Burial 2 X Crematio 4 Donation 5 Other S		ai irom State		Shrobro Cremat		′ ^H (11/1	2/11	Balti	mor	e MD
Baltimore, permit. Pages I an Department of Hea Important: If ite		21. Signature of Funeral Service		3 1	And	22 Name a	nd Address	of Facility	7 1 / 1 /	Z/		IIO	mo DA
Dep De Co		& Dietur	N.K	illia	mo	2148e	N. Fo)1868	i Ave	e.;Ba	THEMST	e,M	me ₂ P <u>A</u> 17
Physician		23a. Part I. Enter the disease, or		at caused the	death. Do no								Approximate Interval
Medical		failure. List only one cause	N.A. Himlm	Iniuries								- 1	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		as a conseque	nce of):							\neg	
		Sequentially list conditions,	b										
	힐	if any, leading to immediate cause. Enter Underlying Cause		as a conseque	nce of);								
	Examiner	(Disease or injury that initiated	С	as a conseque	nce of):								
ted 1 ansit	Ä	events resulting in death) Last	d.	as a conseque	1100 01).								
760, cate be executed physician and the burial - transi	Medical	UNPENDED	AMENDE	D								\neg	
760, Icate be physiciate buriant	B	IF FEMALE:		es, outcome o	f prognancy						23d. Date of o	dolivoor	
		23b. Was decedent pregnant in t			2	Fetal dea	th 3	Ectopic p	regnancy		Month	Da	ay Year
Box 687 e death certiff the attending ed for use as t	흥	past 12 months?		egnant at time		Other (S							
Boy e deatl the atl	Physician			known									
on of Vital Records, P.O. Box ending Physician: The law requires that the death sath. or: After this certificate has been signed by the atte the funeral director, page 2 should be detached for u	Y P	Part II. Other significant condi-	tions contributin	g to death but	not resulting	in the underly	ing cause giv	ven in Part	l.			_	ne cause of death?
ires the signe	d by									1 Yes	2 ✔ No 3	_ Proba	ably 4 Unknown
cords, Plaw requires the has been signous 2 should be d	Completed									24a, Was a autops			opsy findings available impletion of cause of
e law e has ge 2 s	Ē					-				perform	ned? de	ath?	
tal Recision: The certificate ector, page		25. Was case referred to medica					26 Place o	of Death (C	heck only	-	NO I	✓ Yes	2 No
1 of Vital ling Physician: After this certif	Be	examiner?	Hospital: 1	Inpatient	2 ✔ ER/Ou	toatient 3		thor -	Nursing Ho		Residence 6	Other:	
Of Ving Physical Control of Contr	£	1 Yes 2 No 27. Manner of Death	28a D	ate of Injury		ime of Injury	28c. Injury				ow injury occurre		
ading F. Af	틸	1 Natural 5 Pen	ding Jan 4	nth Day Year) , 2011	1504	hrs	1 Ye	es 2 🗸 N	lSuk		strian struck		
Afte rector	icat		stigation 28e. P	lace of Injury	- At home far	m, street, facto	ory office bui	ildina etc	28f	Location (St	reet and Number	or Rura	al Route Number, City
Division of Vital Records, pital or Attending Physician: The law require ours after death. Bertal Director: After this certificate has been similed in by the funeral director, page 2 should b	Certification:	dete	Id not be	ify) Major			.,,			or Town, Sta	ate)		Ilvd, Baltimore , MD
Tospit t hour uner		29a. Certifier				h eccurred at	the time date	and place					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medica	one) 2 Medical Exa	hysician: To the iminer: On the bas	sis of examina									
To vit.	Me.	29b. Signature and title of certific	and manne	er stated.			29c. License				29d. Date signe		
		ASO. A.	a mold .	M			O.C.M	I.E.			January 5, 2		,
		30 Name and address of	who complete	oues of death	/Itom 22-1						, -1		
		 Name and address of persor Melissa Brassell, MD 	Assistant M			900 W. Bal	timore Str	reet. Bal	timore	MD 21223	3		
	ala	31. Date filed (Month, Day, Year)		Registrar's S							·		
Regis		JAN 1 1 2011	6	6	had								

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 00347 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 8, 2011 William . Leroy Queen 12:00 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3707 Plyers Mill Road Kensington Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours December 26, 1919 91 579-10-9136 Virginia **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Montgomery 1 X Yes 2 No Kensington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 3707 Plyers Mill Road 20895 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1943-Black, White, etc. <u>ک</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1945 1 ☐ Yes 2 🔀 No Specify: Specify: "natural" 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 0wner Plumbing and Heating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Ewing Queen Marv Elizabeth Kent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Roy Queen / Son 18115 Samuel Circle, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 13 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) Mt. Zion Cemetery Bethesda, Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Se Vic- Lis nsee Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 atter amais M01305 23a. Pal 1. Exterithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final Demontia Probably of the Alzheimer's Typo Interval Between Onset and Death Years Ph sician/ Dementia Probably of the Alzheimer's Type disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading himmo at cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to lor as a consequence of physician and the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending ph IF FEMALE. 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Atherosclerosis Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law page 2 autopsy death? 1 Yes 2 No Be Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 ื No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Investigation 2 Accident
3 Suicide the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D37142 1-10-2011 Wyl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, M.D. 1355 Piccard Drive, Suite 100, Rockville, Maryland 20850 32. Registrar' State Registrar

P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, perpHYS, G913, 3/16/2011, WS

State of Maryland / Department of Health and Mental Hygiene? 00348 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Elizabeth Russo Jan. 2011 1:20 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riverview Nursing Home Essex Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Nov. 12,1920 Months Days Hours Min 216-12-3186 **Director** 90 Maryland Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MDBaltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 1744 Ellinwood Road 21237 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", XXWidowed 4 ☐ Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Frock Harry Fuegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1744 Ellinwood Road Baltimore, Maryland 21237 Christine Russo (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dopation 6 X Other (Specifyent ombment) cemetery, crematory or other place) of Faith Cem. Gans 1/14/2011 Baltimore, Maryland 21. Signature un ral Servi Duda-Ruck Funeral Home of Dundalk, Inc. 21222 0 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a conseque ce of): Medical **Examiner** vtend-Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed oen 2 signed by the attending physician and defached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical $\pm 2co$ Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I page 2 autopsy performed? Yes 2 N 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 🗌 Yes 2 🗀 No Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu ☐ Accider ☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) 0005517 01/10/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sebas Han 3023 21224 JOLA 31. Date filed (Month, Day, Year) 32. Registrar Signate State Registrar

State Registrar

31. Date filed (Month, Day,

2 Medical Exam

29b. Signature and title of certifier

NG 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MJ 6357 Oxon Hill Road

29d. Date signed (Month, Day, Year)

20745

Oxon Hill, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00350 For State Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day O 7 1739 Physician/ ROBINSON 01 201 SAMUEL W Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** NA Maryland Medical Center BALTIMORE 08 University Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 03-01-33 1 X M 2 □ F Hours 218-26-9069 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County **Funeral Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified a once. 1X□XYes 2 □ No NA MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 237 N. USA Carey Street 21223 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 Specify: American 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Ellicott Machine Co. Welder 11th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Callie Jordan Reuben Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arlene Robinson-Wife 237 N. Carev Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 01-18-11 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility Signature of Funeral Service Licens 638 N. Gilmor Street Baltimore.MD 21217 reste 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Upper gastrointestinal Bleed Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Infection clostridium Difficle Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence of. Examine End Stage Renal Disease the Hospital or Attending Physician; The law lequires that the death certificate be executed ng physician and as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last HRONIC HEART FAILURE Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pulmnary 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed' 1 Yes 2 No Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 1\ Inpatient 2 I ER/Outpatient 3 I DOA 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practice of the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 17802 01/07/2011 1598080186 VINERT L JASSAL MORGYI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 South Green Baltimore JASSAL 31. Date filed (Month Pay Yer) 1 2011 32 registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SHIRLEY RUSS JANUARY 5:08 AM 06 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSHY MARYLAND MEDICAL CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth
(Month, Day, Year)
July 02, 1938 9. Birthplace (State or Foreign Count (Carrett Co. Swenton, Mary Jano 1 □ M 2 👺 F Hours Days 215-36-8792 **Director** 72 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Howard County 1 Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 23a Funeral 2621 Melba Road 21042-1833 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. o, Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced Specify: "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 in and Mental Hygiene.
77 is marked other than "r (Specify only highest grade completed) Howard County Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Librarian Central Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dolph Enlow O'Brien Fannie Myrtle Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a If item 27 is or other trai Ms.Cynthia A. Ross (Daughter) 2621 Melba Road Ellicott City, Maryland 21042-1833 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Forest Hill, Maryland 1 Burial 2 Cremation 3 Removal from State Saturday permit. Page Department of Important: If any injury or once. Exams Fure al Charel and 4 ☐ Donation 5 ☐ Other (Specify) Jan.08,2011 Cremetion Services, Inc. 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Reaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093-2215 **Lic. #M00677** P 1. Enter the issease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner INPECTION SOFT 715506 Sequentially list conditions, it day because Enter Underlying Examiner Due to (or as a consequence of) the attending physician and hed for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? 24 hours after death. Funeral Director; After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 📈 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 🔲 Yes Investigation Could not be 2 No Accident filled in by the Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 152 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in rily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month. Day, Year) RES 000 JAN WARY 2011 address of person who completed cause of death (Item 23a) (Type, Print) 22 S. GREENE ST. BAYIMORE. MANJUNATH MARKANDAYA MD 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 00 A. M ugene 201 Medical 4a. Facility Name (if not institution, give street app 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor MONKJON TIMORE 15 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Se Funeral 1 M 2 □ F Hours **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MO MORE 10e. Street and Number 10g. Citizen of What Country? Funeral USH 2111 roan aNOR 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No. In Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced ortant: If item 27 is marked other than "natu injury or other traumatic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ DRINNE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code, Informant's Name/Relationship (Type, Print) 20a. Method of Disposition
1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Tvans Funcial Cha OREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and A dress of Facility 1.924 21. Signature of Funeral Service Licenses REmation Seurs Monktox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, Approximate shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-transi eroscleros that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death signed by the a d be detached for a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? I ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? Natural Natural 5 Pending within 24 hours area

To the Funeral Director: Aftr 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 2011 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) imoi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2011 Physician/ Month January 4, Thomas McCargo Rankin 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F (Month, Day, Year November 24 Months Hours North Carolina 237-42-3678 Director 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Rockville Montgomery 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 15219 Red Clover Drive 20853 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1963·
If Yes, Give Year or Dates. 1983 Black, White, etc. 1 Never Married 2 K Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College_(1-4 or 5+) 5+ Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Alexander Rankin Lucy McCargo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Rachel Rankin / Wife 15219 Red Clover Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 28, 1 X Burial 2 Cremation 3 Removal from State Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Arlington, Virginia 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myo Cardia disease or condition resulting in death) Medical Due to as a consequence of) Examiner cless Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 2 00 Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation after decth the 6 Could not be Suicide To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0068026 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PADMAJA PRINCE PHILIP OLNEY 20832

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #18 Per FH C911 1/19/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROTH CECILE 2011 09:324M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GENERAL HOSPITAL MONTGOMERY OLNEY MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F October 24 Months Days Hours Year) New York 054-28-0920 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14148 Flint Rock Road 20853 United States 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mus 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Zevart Augusta Carabenien ည Cesar Algen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 15836 Buena Vista Drive, Rockville, Maryland 20855 Susan I. Wright/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 10. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Flushing, New York Cedar Grove Cemetery 21. Signature of Funeral Service Licensee หือปัชาราช Addres Poing Wrey Funeral Home, Rockville, Inc. Haron M01530 300 W. Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a ATHEROSCIEROTIC CARDIOVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if dry, leading to in redicause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2

No 24a. Was an autopsy Yes 2 No Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 01,03,2011 ino 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MMER, 18101 Prince Phillip Drive, Olney Maryland 20832 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>011</u> Physician/ Month January 6, 2:30 P^{M} Phelps Stowell Robertson Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice - Casey House Montgomery Rockville 8. Date of Birth (Month, Day, Year) July 31, 1944 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days 1 **X** M 2 □ F Months Hours Washington, D. C Director 220-42-3782 66 July Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 28a-f must be notified 1 Yes 2X No Bethesda Maryland Montgomery 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5600 Wyngate Drive 20817 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 🛣 Yes 2 🗌 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner or . þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. 3 X Widowed 4 Divorced "natural" Completed Year or Dates. 1966-1972 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Fireman Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Corinne Payne Phelps Wesley Earl Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 Wyngate Drive, Bethesda, Maryland 20817 Corinne P. Prentiss/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 20a, Method of Disposition 20c. Location - City or Town, State January 11, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State any injury or 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland Signature of Funeral Service Licensee Repert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. the 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a dominiquimon of): if any leading to in mediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? 1 Yes 2 No Yes 2 X No 24 hours after death.

Funeral Director: After this certifical eted filled in by the funeral director. 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} \) 2 🖾 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending (Month, Day, Year) 1 X Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined Hospital Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number

124

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, RN

R143201

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RICHARDINE SOARES 3:16 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shannon 3865 1+0 a Social Security Numbe If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) MD Funeral 8. Date of Birth Days 1 🗆 M 2 💢 F 67 Min 215-40-2787 07ººº30°º1'943 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified BALTIMORE 1

Yes 2 □ No MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21213 3865 SHANNON DRIVE or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 🗆 📉 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify:BLACK "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PHARMACY DISTRIBUTION PRODUCT PACKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THEO STEWART RALPH **JEFFERSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3865 SHANNON DRIVE, BALTO., MD 21213 ROBERT JEFFERSON/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Unk 20c. Location - City or Town, State Unk Date UNK 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. Baltinon 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F H INC 21. Signature of Funeral Service Licenses 1701 LAURENS ST., BALTO., MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or ii that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy page death? æ 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Hospital 2 No Other: 1 Yes 4 Nursing Hame 5 ☐ Residence 6 ☐ Other (Specify) |은 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D0069314

Registrar
DHMH 17 Rev 7/2009

State

8813

32. Registrar's Sig

Waltham

Woods

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pasti

Van

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2011 Physician/ Month PM 3119 Evelyn Diane Skipwith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of Baltinure Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F 10/6/1959 Director 217-76-4262 51 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore City 1 No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Harring Court 21213 USA Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin 1X Never Married 2 Married Ś ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black EVELYN Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unit Secretary Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Hudson Ruth Skipwith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Octavia Skipwith (Daughter 215 Harring Court, Baltimore MD 21213 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Green Mount Cem. 11/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature of Funeral Service Licensee 22 14 mme and Address of FacilityPhillip A. Weatherford F.S. Oliver Street, <u>BaltimoreMD</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute myocardial Physician. intarction disease or condition hours Medical resulting in death) Due to (or as a consequence of) Examiner Corenary twenty artern Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Mitral regurgitation 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available Hepatitis autopsy performed? prior to completion of cause of death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiper? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 W Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be execute

State Registrar

31. Date filed (Month, Pay, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surgeon

29b. Signature and title of certifier

Peter W. Chs,

Peter W. Cho, M.D. 2435 West Belvedere Avenue, Baltimore, Manyland 21215

29c. License number

D41120

29d. Date signed (Month, Day, Year)

5, 2011

January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2, 2011 2011 HENRY OTTO SCHULZE 7:01 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KESWICK MULTI-CARE CENTER N/A BALTIMORE CITY Social Security Number Sex 1AΩM2□F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 672477911 216-44-6745 **Director** 99 MARYLAND Usual Residence of Decedent or 28a-f show a notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD N/A BALTIMORE CITY 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 600 W. 40TH STREET 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 Black, White, etc. 1 X Never Married 2 ☐ Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates. WWII WHITE the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S. GOVERNMENT Elementary/Seconday (0-12) College (1-4 or 5+) RESEARCH CHEMICAL BIOLOGIST YEARS + is marked other Be permit. Page 1 and 2 should be filed i Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ REINHARD SCHULZE SOPHIA HERCHE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN S. HUFNAGL/NIECE 206 ZIEGLER ST. MOUNT JOY, PA 17552 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1/5/2011 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 21. Sign June of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, M01139 P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) DDVANCED DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 Yes 2 9 Unknown 2 No be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 performed^a this certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No after death Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the I only one) 29b. Signatu 29c. License number 29d. Date signed (Month. Day, Year) DO059056 3 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 702 West York St Balt Mo Registrar's Signature State auxo Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:30 PM James Grieve Smith Sr. Medical 4a. Facility Name (if not institution, give street and number) City. Town, or Location of Death Coupty of Death **Examiner** arrede tizans | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 7, 1925 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F New Jersey Director 196-18-8102 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X☐ No Harford Churchville Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21028 USA 3209 Rolling Green Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Public Education Educator / Coach Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie M. Smith James (nmn) Smith permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21028 19a. Informant's Name/Relationship (Type, Print) 3209 Rolling Green Drive, Churchville, Maryland Elizabeth Anna Smith / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/7/2011 Churchville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Cemetery Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ hunic andio myoon disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consumence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by er gastro intestinal bluck 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 25. Was case referred to medical examiner? Be of Vital 26. Place of Death (Check only one) Other: 1 🗌 Yes 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural N work? 1 ☐ Yes 2 ☐ No 5 Pending Division Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) within 24 hours a 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific of person who completed cause of death (Item 23a) (Type, Print) evin 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Inko Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Clara Sampson 2:03 4 M January 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Seasons Hospice of Baltimore 5. Social Security Number If Under 1 Year I If Under 24 Hrs 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 1925 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 M 2 Hours Min. (Month, Day, Year) May 1, 1923 No. Carolina Director 217-22-5773 87 Usual Residence of Decedent "natural", or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21216 2903 Mt. Holly Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: **Black** If Yes, Give Specify 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henrietta Covington Thomas Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2903 Mt. Holly Street Baltimore, Maryland 21216 Joseph Sampson 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Owings Mills, Md. 01/14/11 Garrison Forest Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final End-Stage Alsheimers Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner equentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? John (Specify) 1 ☐ Yes 2 ☑ No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of centifier

NSkyapame M.D 29d. Date signed (Month, Day, Year) DOOS7465 3 1835 Smith N-5-203, Baltimore, MD. 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Rajapakse , M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

11-00163 Noel Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend #4a&38fe Bemanyang Department of Health and Mental Hygiene

December of Prince Prince December of New Prince December of Ne			1- For State Registrar		C	ertifica	ate of	Death				F	Reg. No	o		
As pooling and a second process of the process of t								-				Month	Day	Yea		
Early Compan	Medical Examin											January	5, 20	11		1215 hrs
2.16 - 4.4 - 8.9.8.3							4)				's
The control of the co	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birt	hday)								9. Birtl	nplace (State or
Section Text	Director	218-44-8983 1 xm 2 F 63 y							Jays	Hours	Min.	Dec.2	23,1	947	Cou	ntry) MD
The control of the	b	-														
The property of the property o	*		,	127				n								
The property of the property o	rland -f sho	ġ		George	La	aure.	<u> </u>									
The property of the property o	Mary r 28a	Jec C											_		at Coun	try?
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	th the	의												A		
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	tems	Je i				U.S.							0-			an Indian, Black,
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	er de			1 X Yes		_	4 🗀 ,	Vac 2424	No. o	nooif a				Casaifu	rah i t	-0
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	urs aff tural'	핡	15. Decedent's Education (Spe	or Dates: cify only highest gra	1966-6 ide completed)						of work	done	16b.			
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	72 hor	살														,
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	036 ithin ne.	ē	9			Pr	incip	ole Of	Eic∈	er			Ţ	Jnion		
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	Hygie of the A		• •	•							•			,		-
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	121 I be fi ental erked															
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	Shoulc and Mr	٩														
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	Mind 2 salth a	1		Wife	Lanh											
A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: West A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5 Other Specify: A Donation 5	Ore es!a ofHe			n 3 Removal fi					cemete					Location -	City or 1	own, State
Approximate interview and provided and provi	Fag. Pag. ment				We	est A					2011	-	Oc			
Approximate interview and provided and provi	Bali Sermit Impor			Licensee												e, P.A.
Reliver List only one cause on each line. Between Onset and Death		+		complications that o												Approximate Interval
Sequentially list condition, insulting in death) Due to (or as a consequence of): Due to (or as a conseque		- 1	failure. List only one cause	on each line.			t enter the	inioue or uy	ig, suci	ii as caigia	ac or res	piratory an	est, sr	ock, or near	1	Between Onset and
Sequentially list conditions, fary, leading to immediate cause. Either Underlying Cause events resulting in death) Last Sequentially list conditions, fary, leading to immediate cause. Either Underlying Cause events resulting in death) Last Sequentially list conditions, fary, leading to immediate cause. Either Underlying Cause events resulting in death) Last Sequentially list conditions, fary, leading to immediate cause. Either Underlying Cause events resulting in death) Last Sequentially list conditions, fary, leading to immediate cause. Either Underlying Cause events resulting in death) Last Sequentially list conditions, fary, leading to lead to	Examiner															Death
February February			Sequentially list conditions		a consequence	017.										
AMENDED Description of the part of the		힐	if any, leading to immediate	Due to (or as a	consequence	of):								_		
AMENDED Description of the part of the		Ē	(Disease or injury that initiated	Due to (or as a	consequence	of)·						_			-	
past 12 months? The post of the post of	uted Id ansit	ונ	events resulting in death) Last	·	. comoqueme	01).									-	
past 12 months? The post of the post of	exectian ar	<u> </u>	UNPENDED	AMENDED	_		-									
past 12 months? The post of the post of	60, ate be	ĕŀ			outcome of pre	gnancy							23	d. Date of d	elivery	
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	687 ertific ertific ding p			Live			Feta	death	3E	ctopic pre	gnancy					y Year
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	eath c	2	1 Yes 2 No 9 Unk			eath 5	Othe	r (Specify)					1			
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	the d	5	Part II. Other significant conditi			resulting	in the und	derlying caus	e given	in Part I.		23e. Did to	obacco	use contrib	ute to th	e cause of death?
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	P.C	6										1 Ye	s 2	No 3	Proba	bly 4 Unknown
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	ds,										-	24a. Was	an	24b. W	ere auto	psy findings available
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	COT law i has b		-								-					mpletion of cause of
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	The The		OF Management to modical					00.5					2 N	io 1	✓ Yes	2 No
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	iceto	Ĭ	examiner?	Hospital:	nnationt 2] EB/Out	tnationt "			-			Danid		Oth (
State 31. Date filed (Month, Pay, Year) No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 1 Yes 2 No Subject shot self FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse FOUND: 1157 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse Part of the part of t	Phy S Phy eral d	- to		28a. Date	of Injury		·	-								
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29c. License number O.C.M.E. 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature			Pend	ina i				1	Yes	2 🗸 No						
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29c. License number O.C.M.E. 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	r Atter des irecto	2		28e Plac				factory, offic	e buildir	ng, etc.	28f.	Location (Street a	and Number	or Rura	Route Number, City
A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Determine 1 Check only 1 Determine 1 Determine 1 Determine 1 Determine 1 Determine 2 Determine 2 Determine 2 Determine 2 Determine 3 Determine 2 Determine 3	oital o		deter	market and the second	Townhous	e					129	or Gylras 40 Glaytor	CEOI	Driv , Laurel, N	r e /ID	
O.C.M.E. January 6, 2011 30. Name and deddress of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Hosp 24 ho Func etely f	- 1 2	29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowled	dge, deat	h occurre	d at the time,	date ar	nd place, a	and due	to the caus	e(s) ar	nd manner a	s stated	
O.C.M.E. January 6, 2011 30. Name and deddress of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	No the sithin complete complet	٦ ا	2 🖳	and manner s		and/or inv	vestigation	n, in my opin	on, dea	th occurre	d at the	time, date	and pla	ace, and due	to the	cause(s)
30. Name and eddress of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Figistrar's Signature		2	29b. Signature and title of certifier		/	1 >		29c. Lice	nse nur	nber			29d.	Date signed	(Month	, Day, Year)
Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			WM	7	DU	17		0.0	C.M.E				Jan	uary 6, 2	011	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(X)	3	/ "	Barrett .								74-5				
State 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature							900 W	. Baltimo	e Stre	eet, Balt	imore	, MD 21	223			
			JAN 1 1	2011 32.	gistrar's Signat	ure	hour	2								

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Janaury 7 ^{Day} 2011 1:05 a M Shirley Marie Stevens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hill Court, # T-2Catonsville 2 Summit 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours Min. Apr. 5 Yel 931 79 Maryland 218-28-2903 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location Director Catonsville Baltimore MD1 Yes 2 No 10e, Street and Number 10f. Zip Code ō 10g, Citizen of What Country? iral", or items 23a or Examiner must be r Funeral United States 21228 2 Summit Hill Court, # T-2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Bace - American Indian Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates "natural", 3 ₺ Widowed 4 □ Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumation once. Be 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Murphy 17. Father's Name (First, Middle, Last) ည Charles W. Ganley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 Fern Way, Eldersburg, MD 21784 Renee Schoff - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemptery, crematory or other place) Burial 2 Cremation 3 Removal from State 1-11-2011 Baltimore, MD Loudon Park Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. re o Filmeral Se vicelLice 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ elocysolo disease or condition Medical resulting in death) Due to (as a consequence of) **Examiner** Sequentially list conditions. Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballo MD 1120 N. Kolling RD Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard Carl Stiefel, Sr. MUARY 01:18 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. 05, 1933 213-30-2655 Months Days Hours 78 Director Baltimore, Maryland Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Parkville Baltimore Maryland 1 🗆 Yes 2 🛣 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country?
United States Examiner must be 23a Funeral 21234 8410 Old Harford Road hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🜠 No If Yes, Give Year or Dates. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced Specify White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry filed within 72 he tal Hygiene. Id other than "na (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stiefel Bakery Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever 0 Mary A. Focht Otto Conrad Stiefel Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1510 Bollinger Road Westminster, Maryland 21157 Department of Health ar Important: If item 27 is any injury or other trau Richard Stiefel, Jr. (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Cardens of Faith Cemetery January 10, 2011 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help tiglure. List only one cause on each line.

Immediate Cause Fhal Interval Between Onset and Death Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for se's consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within Etherus there death.

To the Zuneral Director: After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MYOCARDIAL INFARCTION 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Tes Other: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 30263 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND M.D. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHOPE Physician/ MICHAEL 07.37 AM JANUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE WASHINGTON MEDICAL LEUTER ANNE ARUNDEL BUKNIE GLEN 8. Date of Birth
(Month, Day, Year)
April 9 1979 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 31 Months Hours Director 218-92-0002 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2X No Glen Burnie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 7024 Ingrahm Drive 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 X Never Married 2 Married 1 Yes If Yes, Give 2X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 횬 Ronald Shope Nancy Sierko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Big Baer Drive Glen Burnie, MD 21061 Nancy Shope / Mother SHOPE, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan Date 13 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Glen Haven Mem. Park 2011 Glen Burnie MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Fundal Service Licman, Services PA 1 2nd Ave Sw Glen Burnie MD 21061 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) DISTRESS SYNDROME Examiner RESP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner 1 Yes Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 000650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLENBURNIE, 21061 Dr. JANAKI DEEPAK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

HMH 17 Rev 7/2009

Registrar

JAN 11 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8^{Day} Month Physician/ 2011 8:15 P M Jan. Vivian A. Schreiber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium 8. Date of Birth (Month, Day, Ye July 25 7. Age (In yrs. last birthday) Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 QF Hours Director 93 1917 162-12-9822 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important if item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 2300 Dulaney Valley Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes 1 ☐ Yes 2 x No Specify: If Yes, Give Year or Dates white Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Esther Killinger Thomas McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Schrieber/son 15819 York Rd., Sparks, MD 21152 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) Calvary Cemetery Assoc. 1/12/11 Altoona, PA Sign ture of Funeral S. . Lic osee Temmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rea disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 2 X No Other: မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider 5 Pending injury 1 Yes 2 No Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer nuary 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD M.D.ERNESTINE WRIGHT 32. Registrar's Signat State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00366 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 10^{Pay} 2011 ear Ronald James Shaver 5:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Days Hours Min Oct. 2 1940 1**X**□ M 2 □ F Director 70 219-38-6939 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Baltimore Cockeysville MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21030 USA 300 International Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: white Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail 12 n/a Display Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alma Mae Harding Robert W. Shaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Michael May/POA 107 Maiden Choice Ln., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Lakeview Memorial Park 1/14/01 Sykesville, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. <u>Padonia Rd., Timonium, MD 21093</u> Singure Funga Syrvice Licenses Bryan W. Clary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and defacted for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has page 2 autopsy 2 \square No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation ☐ Suicide ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I or ly one 29c. License number 29d. Date signed (Month, Day, Year) 20071287 (Item 23a) (Type, Print) Name and address of person who completed cause of death 70 31. Date filed (Month, Day, 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Leroy Smith Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3. Mir Health + Mi If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex. 1 ☑ M 2 ☐ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Sept. Day Year 1913 Perinsylvania 212-38-2359 97 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 609 S. Shamrock Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian rmed Forces?
Yes 2 \(\subseteq \text{No} \) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 In and Mental Hygiene.
I is marked other than "r Elementary/Seconday (0-12) Public Education Supervisor Of Curriculum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Jane Williams Matthew Logan Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is. Victoria Kennedy / daughter 609 S. Shamrock Road, Bel Air, Maryland 21014 20a. Method, of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ R 01-15-2011 Bel Air, Maryland 4 Denation 5 ther (Specify) 21. Sign 22. Name and Address of Facility McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day signed by the a d be detached f g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 % autonsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier i 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 756545 41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD CHOSLA W. MACPLIAIL 615 Date filed (Month, Day, 32. Registrar's Signature State JAN 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 \mathbf{P}^{M} Margaret Doris Soloway January 6:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Riverview Care Center **Fssex** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 M 2 X F Days Min 05/26/1925 **Director** 219-10-9552 Maryland 85 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic according to the contraction. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore **Essex** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6820 Kelso Drive 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service 12 Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jamie Markheim Samuel Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6205 Calloway Drive, McKinney, Texas 75070 Michael Soloway (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory, Inc. 1/8/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Dicensee Bruzdzinski Funeral Home, P.A 1407 Old Fastern Avenue, Essex, Maryland 21221 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death r heart failure. List only one cause on each line. shool Immedi de Cause (Final Physician/ ement19 disea or condition resulti in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Que to for as a nonsequence off if any leading to immediate. Enter Underlying Physician/Medical Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗀 No within 24 hours after death To the Funeral Director: A Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

15 State 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 1 1 2

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Sig

29d. Pate signed (Month, Day, Year)

116

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0837 M ZOIL Medical 4a. Facility Name (# not institution, give stre 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 3 🗷 F Months Days Hours Min. Nov 24, Year) . Korea 80 S. Director 558-32-1953 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 No Delaware NY Bovina 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 2391 Scutt Mountain Road 13740 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 ☐ Divorced Asian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Entertainment Opera Singer Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tl Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herbert. S. Kim Sook Lee Kyuna of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adam Slote/son 512 Old Pasture Lane Severna Park, Maryland 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/10/2011 Woodbine, Maryland . Sign re of Funeral Service Going Home Cremation Service P.O. Box 784 formas wite (2 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No SEProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the be st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 15 e of death (Item 23a) (Type, Print) 445 亡 N 32. Registar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>011</u> Physician/ 4. A M Lynn Howard Smith January 1:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 3. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** 1 X M 2 □ F Director 199-14-7173 89 Pennsvlvania Usual Residence of Decedent show 10a. State 10b. County uld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 2302 Veirs Mill Road 20851 United States items 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner n 14. Race - American Indian, Black, White, etc. WWII 1 Never Married 2 M Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates er than "nature, the Medical E Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Pastor 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Cyrus Smith Laura Elliott and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Lorraine R. Smith/Wife 2302 Veirs Mill Road, Rockville, Maryland 20851 20a. Method of Disposition 20b. Place of Disposition (Name of Cornetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott January 9 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremătorium, Inc. 2011 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, Maryland 21. Signature of Funeral Service License Inc ain M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicianz disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of): Examiner Myocardial Infarction Secretar tinity flat exercitions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury The law requires that the death certificate be executed Severe Aortic Stenosis sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Dav Year ed 1 9 Unknown 9 Unknown cate has been signed by i page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 No Yes 2 V No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death the funeral 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe D0055856 January 4, 2011 1211

State Registrar 1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

M.D.

Negash Ayele, 31. Date filed (Month, Day, Year)

JAN 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JANUARY 09, 20 1 1 3:35 P M SYLVIA SILBERG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🗓 F Days Min. 0671871918 220-09-6799 92 **Director** MDUsual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 ☐ Yes 2 X No MD BALTIMORE RANDALLSTOWN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8409 ALLENSWOOD ROAD 21133 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. è Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: 3 ₩Widowed 4 □ Divorced WHITE Year or Dates t of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ TRETICK JOSEPH RACHEL UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HALAINE STEINBERG / DAUGHTER 11201 VALLEY HEIGHTS DRIVE OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/10/2011 BALTIMORE, MD Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Privsician/ W Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of: Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be selected that after death.

Funeral Director: After this certificate has been signed by the attending physicia et all filled in by the funeral director, page 2 should be detached for use as the burn in the funeral director, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X N 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one) 29b. Signature

> Smith AVL Suite 203 WILLUITE 2835 32. Registrar's Signature

deress of person who completed cause of death (Item 23a) (Type) Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Robert A. Taylor Jr /Medical Jan.3 2011 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Future Care Charles Village Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **X**□M 2□ F Min. 219-38-8584 Director 68 MD May 29,1942 Usual Residence of Decedent with the Maryland 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Director Baltimore 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2312 Hamilton Ave. 21214 death \ Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker <u>12th</u> Bethlehem Steel permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, <u>the north or other traumatic event</u>, <u>the sevent</u>, the content of the conte 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert A. Taylor Sr. Coretha Winston ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Taylor (wife) 2312 Hamilton Ave. Balto, Md. 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Cedar Hill Cem. 4 Donation 5 ☐ Other (Specify) Jan. 12, 201 A.A.Co, MD 21. Symplure of Funeral Service License 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Preston St. Balto, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any and high of in modat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence or Examine attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No. o 9□Unknown 9 ☐ Unknown ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has l 24a. Was an page 2 certificate Division or Vital 1∐ Yes 2 No Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA **1** Nursing Home After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural death. 2 Accident 1 Tes 2 🗆 No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) Mam Woods

HMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month idney Havolo unev 10:55 PM Medical 06 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A VA-Baltimore Rehabilitation & Extended Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 ¥ M 2 □ F Days Months Hours Country) Penn. Month, Day, Dec 22, Year) 1925 Director 206-14-3621 85 Usual Residence of Decedent shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits N/A 1 Yes 2 No **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Meridene Drive - #202 U.S.A. 21239 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 ☐ Never Married 2 🙀 Married Completed by Black, White, etc. Baltimore, Maryland 21215-0036 1944 1 Tes 2 X No Specify: 3 Widowed 4 Divorced Black Year or Dates 1946 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unisys Corporation Logistics Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sidney Tanner Gladvs Tanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Meridene Drive # 202 Baltimore, Maryland 21239 Charmaine D. Tanner 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 01/12/11 Catonsville, Maryland Metro Crematory, Inc. Signature of Fineral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Itiple Medical Due to (or as a co sequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ed by the a detached f 1 Yes 2 g Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🖼 No 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 Tes 2 No ည within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and vitle of certifie 097804

State Registrar

2

DHMH 17 Rev 7/2009

howire

Andrew

31. Date filed (Month, Day, Year)

JAN 11 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mooniee

32. Registrar's Signature

01/06/2011

J900 Lock Raven Blud Balkinow MD C1218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 99:20 W Medical 4a Facility Name (if not institution, give street and number, **Examiner** 1020 8. Date of Birth (Month, Day, Year) If Under 1 Year If Linder 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 219-38-1396 Country) Director 69 1941 Baltimore, Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Directo Maryland Baltimore 28a-f Lansdowne 1 Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2622 Tulip Avenue 21227 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by "natural", or 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: White Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked ပ္ John Storey Velma German 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Lynn Kennedy (Daughter) 3132 Rosalie Avenue Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Funeral Chapel Eal Air Januáry 10, 2011 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Crematics
8800 Harford Road Parkville
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 Interval Between Onset and Death Ph sician/ Due to (or as a co sequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause E turn certying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 Unknown should be detached a Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 💘 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s this certificate has perform 2 🗌 Ŋo 1 Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending PP within 24 hours after death.
To the Funeral Director: After th completed filled in by the funeral Manner of Death 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🔲 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

_awrence vvalker	1- For State Registrar	epartment of Health and Mental H Certificate of Death	ygiene Reg. No. 2	00375
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Lawrence Walker		Date of Death Month Day Year January 6, 2011	3. Time of Death 1420 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c, County of Death	1
Funeral	1931 W. Fayette Street 5. Social Security Number 6. Sex 7. Age (In v	rs. last birthday) If Under 1 Year If Under 24Hrs	N/A 8. Date of Birth (MM/DD/YYYY) 9. Bir	thnlace (State or
Director	unk 1 M 2 F 65	Months Days Hours Min.	Foreig	
v any		City, Town or Location		10d. Inside City Limits
yland -f show	MD N/A	Baltimore		1 X Yes 2 No
the Maryland a or 28a-f sh tified at once		10f. Zip Code	10g. Citizen of What Cour	,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1931 W. Fayette St. 11. Marital Status 1. Never Married 2. Married Armed Forces?	in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - Ameri	ican Indian, Black,
er death , or ite	1 Never Married 2 Married Armed Forces? 1 Yes 2 X N			1
ours aft stural samine	15. Decedent's Education (Specify only highest grade completed	d) 16a. Decedent's Usual Occupation (Give kind of w	Specify: $B1a$ vork done 16b. Kind of Business/I	
	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade	during most of working life. DO NOT use retin		
5-00; ed with sygiene other ti	17. Father's Name (First, Middle, Last)		Esshay me	eats
21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical To Be Comple	Lawrence Davis	Gertrud	e Walker	areas and a second
MD 21 d 2 should th and Me n 27 is ma numatic ev	19a. Informant's Name/Relationship (Type, Print) Traci Byrd(neice)	19b. Mailing Address (Street and Number or R		
Te, N 1 and 1 Health fitem 2 r frau	20a. Method of Disposition 20	0b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or	212()7 Town, State
	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Joseph Brown F/H And Crematory 01/	10/11 Baltimor	e,MD
Balti Permit. Departm Importa	21. Signature of Funeral Service Licensee	no 22. Name and Address of Facility Own 2140 N. Fulton	Jr. Funeral Ho	me PA
Physician	23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.	eath. Do not enter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval
/Medical Examiner	Immediate Cause (Final disease a. Atherosclerotic Card			Between Onset and Death
التعرم مع	or condition resulting in death) Due to (or as a consequence b.	ce of):		
iner	if any, leading to immediate Due to (or as a consequence for the Underlying Cause)	ce of):		
tted J ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	ce of):		
50, te be executed sysician and burial - transit	d. AMENDED			
760, cate be physici the buri	IF FEMALE: 23c. If yes, outcome of p	regnancy	23d. Date of delivery	
Box 6876 death certificate the attending phy of for use as the nysician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of	2 Fetal death 3 Ectopic pregnar f death 5 Other (Specify)	ncy Month D	ay Year
He to the feet	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but no			
P.O. rres that the signed by be detac	contributing to death but he	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to t	
of Vital Records, ng Physician: The law requires ther this certificate has been signeral director, page 2 should be 1: To Be Completed				opsy findings available ompletion of cause of
Reco			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	
Vital Regardian: The his certificate director, page	25. Was case referred to medical examiner? 1 Voc. 2 No. 1 Impatient 2	26. Place of Death (Check of D		
n of V ding Phys . After thii funeral di	1 ✓ Yes 2 No Inpute 12 27. Manner of Death 28a. Date of Injury		Home 5 Residence 6 ✔ Other: 28d. Describe how injury occurred	Scene
ision Attendiar death. rector: A by the fu	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		
i Digi ≤	4 Homicide determined (Specify)	at home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Run or Town, State)	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred at	lue to the cause(s) and manner as stated the time, date and place, and due to the	d cause(s)
2	296. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month	th, Day, Year)
	30. Name and address of person who completed cause of death (It		January 7, 2011	
	Laron Locke MD. Assistant Medical Examine	900 W. Baltimore Street, Baltimore, M	D 21223	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Sign	barle		
DHMH 17 Rev 1/2001 OCME 2006	OCME	ORIGINAL		

1-00209 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. obert Allen White State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 7, 2011 Medical Examiner Robert Allen White 1600 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Potomac River Point of Rocks Frederick 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Director UNKNOWN Country)Virginia 1 X M 2 F 55 11/06/1955 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Prince William Nokesville 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14008 Hunter Hill Lane 20181 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1X Yes If Yes, Give Yeer 1982-86 White 4 XX Divorced 1 Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Postal Postal Worker Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Maurice A. White Be Shirley L. Dempsey 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14008 Hunter Hill Ln., Nokesville, VA 20181 Shirley L. Dempsey / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Department o Metro Crematory Inc 01/11/2011 Baltimore, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - trans Physician/Medical X UNPENDED 23a,27,28a-f per me g913 3-10-11 vt AMENDED the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth attending I 2 Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Ģ g Unknown signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? page certificate Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural fd 1315 hrs 1 Yes 2 X No Director: 24 hours after death. fd 1-7-11 subject drowned 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Potomac River-Point of Rocks Frederick, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined (Specify) 4 Homicide potomac river 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 8, 2011

1 okal

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:00 AM Medical 4b. City, Town, or Location of Death cility Name (if not institution, give street and numb 4c. County of Death **Examiner** altimor *Forest* 8. Date of Birth Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 6. Sex **Funeral** Months 84 Yrs Days 1 🗆 M 2 🖼 🗗 Hours **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director be notified 1 Nes 2 No Hmore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö th and Mental Hygiene. 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b Funeral 2121 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MPloveo 3amst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Ave tarks Henson Balto torest helma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition з 🗆 1 Surial 2 Cremation alti Mae rclaun 4 Donation 5 Other (Spe unera of Fun val Service Licen. 22. Name and Address of Facility Balto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Calorie Pnysician/ ROL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) rears or Attending Physician; The law requires that the death certificate be executed for use as the burial-transit a and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Pregnant at time of death 1 Yes 2 No g Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ been signe should be c Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 No death? director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural injury 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Syaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Checi 29d. Date signed (Month, Day, Year) Signature and title 29c. License numbe 2011 who completed cause of death (Item 23a) (Type, Print) MD 3512 Newlan

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 45 AM Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. South of Death Town, or Location of Death 20 SUN 5. Social Security Numbe 6. Sex Age (In yrs. last bjrthday, If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, 1 M 2 M Months Days Min Director Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No celtimore 10e, Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 √Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🖾 No If Yes, Give Specify "natural", 3 Divorced Marines Year or Dates. the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than /Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, 2 should be . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Page 1 and 2: Department of Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Reproval from State cemetery, crematory or other place injury or 5 Other (Specify) Fineral Se 22. Name and Address of Facility any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line, ediate Cause (Final ase or condition little in death) Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 4 ☐ Pregnant 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗆 No 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident Suicide Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie Day, Year, 30. Name and address son who completed cause of death (Kem 23a) (Type, Print) 69

State Registrar 31. Date filed (Month, Day, Year)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 300 WADDELL Physician/ ERNESTINE January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner HOSPI tal Porthwest Randollstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 212-28-74 1 🗆 M 2 🕟 Months Country) 78 Yrs. N.C Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director altimou 1 Ses 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Edmondson 2122 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ₩idowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Kesturant -Employed Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 1+ more 12011 4 Donation 5 Other (Specify) Memoria 21. Signatur of uneral Service Ly 22. Name and Address of Facility salto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Price monia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year 1 ☐ Yes 2 ₪ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Director: After this certificate 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\bar \) No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 A Natural 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

Abdallah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

Kafrouni

D 65843

5401 Old Court Road, Randallstown, MD 21133.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Day 2011 7:45 pM MARGARET MARIE WEAKLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Autumn Assisted Living Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8, Date of Birth Date of Day, Y (Month, Day, Y 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Director 87 215-20-4014 March Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ral", or items 23a of Examiner must be Funeral 21742 20404 Chuck Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ξ Baltimore, Maryland 21215-0036 nan "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) filed within 72 al Hygiene. life. DO NOT use retired) Operator Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Sears 12th Ø Telephone/Switchboard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even ပ Margaret Brimmer Roy J. Athey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chuck Lane, Hagerstown, MD Janice Erickson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/13/2011 Burtonsville, MD Union Cemetery 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01103 313 Talbott Avenue, Laurel, MD 23a. Part f. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SCLBROTIC CARDIO VASCULAR disease or condition resulting in death) ARTERIO Medical Due to (or as a consequence of): DUSEASE Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, PERIPHERAL To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DISEASE DEMENTIA performed' 2 🗆 No 1 Yes Yes 2 과 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No the viole Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) 5515766 UP 18 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d, Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier PDD 18019 the MO

State Registrar

DHMH 17 Rev 7/2009

VASAUT

31. Date filed (Month, Day,

MILL ST. HARRESTOWN

MD

21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 750AM Medical noninstitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore City 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Funeral Days 1 💢 M 2 🗆 F Months Country) Director 213-26-8994 81 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Exercises. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Edgemere 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2611 North Marine Avenue 21219 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married XX Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify. Specify. 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Years Steel Worker Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Whitlock Madeline Fletcher 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Loretta G. Whitlock 2611 North Marine Avenue Edgemere, Maryland 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 1/11/2011 Middle River, MD 21. Sign ur of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dunda1k Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ CUNCE Medical Due to (or as a Examiner Dequentiony list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed to the second because the second of the se Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N page death? certificate 2 🗆 No Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation neral Director: A Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a

To the Funeral C

completed filled Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 900 Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

00382

3. Time of Death

8:25

10d. Inside City Limits

Approximate Interval Between Onset and Death

YEAR

Day

2 🗆 No

29d. Date signed (Month, Dav. Year)

501

Year

GEN BURNE

White

1 ☐ Yes 2 No

State Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIETHI

29c. License number

1600 CRAIN

D5(32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 2011 Walton Dismukes Wilson 10:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 405 S. Hammonds Ferry Road Linthicum Anne Arunde1 Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days **1X**□ M 2 □ F Hours Min. July 3, 1923 Country)
Maryland 87 218-26-1827 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director MD Anne Arundel Co. Linthicum Heights 1 Yes 2 N No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? **Funeral** 405 S. Hammonds Ferry Road 21090 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2XX Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: "natural", 3 Widowed 4 Divorced WWII White Year or Dates of Health and Mental Hygiene.
of Health and Mental Hygiene.
fitem 27 is marked other than "natur other traumatic event, the Medical! 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Real Estate Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Owner Development Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilson, Sr. Frankie Dismukes Robert Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Irene Ann Wilson / Wife S. Hammonds Ferry Road Linthicum, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Durial 2 Cremation 3 Removal from State 4 □ Donation 5 🖾 Other (Specify) Entombment Lorraine Park Cem. 1/14/2011 Woodlawn, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service-M01121 1 2nd Ave SW; Glen Burnie, MD 21061 Services PA; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between inset and De al Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital 2. No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 4
Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

1 1 2011

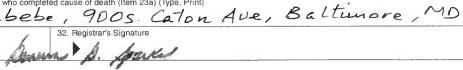
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 09:26AM Evelyn A. Whitt 04 2011 anuam /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore nes If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days Months Yrs. 216-72-4616 Nov. 9 1959 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2X No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 215 B Suiter Rd. 21228 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 If Yes, Give Year or Dates: 1 ∐Yes 2 🛣 No Specify: Specify: White ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other the any Injury or other traumatic event, Insupplied. N/A Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herschel J. Massey, Jr. Evelyn L. Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walter Lee Seidel/ Son 215 B. Suiter Rd., Catonsville, Maryland 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crematory,LLCJan. ,2011Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europe Service Licensee 22 Name and Address of Eacility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 22 **Physician** obable disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is death), act Due to (or as a consequence or, Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans EKTIFICATION APPROVED resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an lentilator this certificate had director, page Respirator tailure 1 □Yes 2 ☑No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐ Yes 2☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred Subject overdosed husself on Medications 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at After UNKNOWN 5 ☐ Pending investigation 1 Natural Dec 13 2010 1 ☐ Yes 2 Accident within 24 hours after deatt

To the Funeral Director:
completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1427 EOSTEN AVE BAHTINDE, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P25480

State Registrar

Say 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debebe

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State o	of Maryland / De C	partment of F ertificate of			leg. No.	d days, year	00385	
	Physicia		Decedent's Name (First, Middle, La Mary J.		Wolfe			2. Date of Dea Month January	Day	Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, given 438 Trappe Road	e street and nu	mber)		r Location of Deat	h	4c. County Balti			
	Funeral Director		5. Social Security Number 6. S 227–34–2768	Sex 1 □ M 2 💢 F	7. Age (In yrs. last birthda 81 Yrs.	Months Davs	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day October) _{Year)} 19 , 1929	Coun	lace (State or Foreign try) gton, Virgini	
	Aaryland I ehow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Baltir	nore	10c. City, Town or	Location Dundalk				10	0d. Inside City Limits	
	with the h	Funeral Director	10e. Street and Number 438 Trappe Road			10f. Zip Code 21222		1	10g. Citizen of V USA	What Coun	try?	
936	filed within 72 hours after death with the Maryland Hygiene. Hygiene Insturelt, or Items 23a or 28a-f ehow the the Modical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec Armed F 1 Yes If Yes, G Year or I	2 X No ive			Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White, o v: Wh:		
Maryland 21215-0036	within 72 hor ene. than "naturi ne Modical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12 years	ade completed)	(G. life	cedent's Usual Occup ive kind of work done b. DO NOT use retire sistant Ma	during most of wo d)	rking	16b. Kind of Bu		ustry Uniforms	
land 2	uld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Las Lacie Elmer Humph			January 12	18. Mother's Na	me (First, Middle, Huffman	Maiden Surnarr	ne)		
্। ore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mantal Hygiens. Institutely or flems 23a or 28s-1 ehow important: It fem 27 is marked other than "natural," or flems 23a or 28s-1 ehow any Injury or other traumatic event, the Modical Examinar must be notified at once.		19a. Informant's Name/Relationship Edna Her1 20a. Method of Disposition 1X Burial 2 □ Cremation 3 [sist	7602 20b. Place of Discometery, Commetery, ommeter, Commeter,	ailing Address (Street Parkwood sposition (Name of trematory or other pla	Road, Du	undalk,Ma Date Jary	aryland 20c. Location -	212: City or To	22 wn, State	
Baltimore,	permit. Pag Depertment Important: I any Injury o		4 Donation 5 Other (Special Signature of Funeral Service Lice	fy)	Ione Sta	ar Baptist Connelly 7110 Soll	Funeral 1	Home Of D	Covingto Dundalk, Dundalk	P.A.		
	Control of the product of the produc	dical Examiner	23a. Part1. Enter the disease, or ponshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ar Due to Due to c.	caused the death. Do not each line. (or as a consequence of): (or as a consequence of):	1 0 1.	ng, such as cardia				Approximate Interval Between Onset and Death	
Box 6	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	1 ☐ Live	nant at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		1	ite of delive	ery Day Year	
rds, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to	death but not resulting in th	e underlying cause gr	ven in Part I.	1	obacco use cont	acco use contribute to the cause of death? s 2 No 3 Probably 4 Únknown		
l Reco	itcien: The law rec certificate has bee rector, page 2 shor	Completed						24a. Was a autop perfor 1 🗆 Yes	rmed?	prior to col death?	psy findings available impletion of cause of	
Division of Vital Records, P.O	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director. To the Funeral Director completely filled in by the funeral director.	To Be	1 Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other 4 □ Nursing Home 5 N Residence 6 □ Other (Specify)								(y)	
Divis	itel or Atters after dearest Director	Certification:	3 Suicide 6 Could not 4 Homicide determined	200. Fiau	e of Injury - At home, farm, fing, etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,	
	thin 24 hour the Funer the Funer mpletely fill	Medical		miner: On the	e best of my knowledge, d basis of examination and/o nner stated.	r investigation, in my		urred at the time, o		and due to	the cause(s)	
	/ O		3. Name and address of person who	D a	ise of death (Item 23a) (Ty Trimble H.				-			
	Sta	te	Philip Militello 31. Date filed (Month, Day, Year)	MD 6	Trumble H. Registrar's Signature	11 CT. Luth	enville	Md, 2	21093			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Beath Physician/ Month 10 JANNAY RAYMOND WILSON YOUNG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD FOREST HILL HART HERITAGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 23 Birthplace (State or Foreign Country)
 Maryland Social Security Number **Funeral** 7. Age (In yrs. last birthday) Days 1 🔀 M 2 🗆 F **Director** 1919 219-01**-**7766 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Street 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1417 Trappe Road 21154 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 X Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ₩Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Superintendent 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Highway Construction & Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Walter Christian Young Rosa Lillian Bolth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Lenane / Daughter 3168 Old Forge Hill Rd., Street, Maryland 21154 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Bel Air Memorial Gdn 1-14-11 1 Burial 2 Cremation 3 Remov I from State Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Sign ature of Funera MCCOMAS FUNETAL HOME, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Par 1. Enter the dis use, or complications that caused suck, or heart failure. List only one cause on each line. aused the death. Do not enter the mo 😽 of dying, such as cardiac or respiratory arrest, Interval Between Onlie and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral inversion, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Year 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 🕢 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: Assisted Livin 1 Tes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my policies death occurred at the cause of examination and/or investigation in my policies. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIII TOME 32. Registrar's Signature 31. Date filed (Month, Day, JAN 11 Registrar

			amend #5	Per FH g914 State of Maryla	4/14/2 ind / Dep	011 JH artment of	Health and N	Mental Hy	giene	•			
		•	For State Registrar	Certificate of Death					Reg. N2 0 1 1 0 0 3 8				
	Physicia	ın/	1. Decedent's Name (First, Middle, Las	B. Zande	11.			2. Date of Dea Month	ath Pay Year	3. Time of Death			
\$	Medic Examin		4a. Facility Name (if not institution, give		ul	4b. City, Town,	or Location of Death	1	4c. County of Dea				
32	ź.		Joseph Richey Ho	spice			1timore		N/A				
io	Funeral Director		5. S 213 20 1867 6. Se	7. Age (<i>ln yr</i> s	a. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Pa 08/04/	th 9. Bi	rthplace (State or Foreign ountry) ennsylvania			
00	3		Usual Residence of Decedent 10a. State 10b. County	1100 /	City, Town or Lo	antion		1 00/ 0 1/	.,20				
-	faryland Ba-f sh tified a	Be Completed by Funeral Director		Arundel	Baltir					10d. Inside City Limits 1 ☐ Yes 2 🖾 No			
ા)ાવી	h the N ka or 20 be no	al Dii	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?			
-	ath with	nner	103 Bon Air Ave	2. Was Decedent Ever in U	18 13		21225	ecify Yes or No-	U.S.A.	origon Indian			
	fter deg	by F	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔀 No			Hispanic Origin? (Spoan, Mexican, Puerto	Rican, etc.)	Diddin, TTI	te, etc.			
24 m Delli	ours af atural" sal Exe	eted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 Yes 2 X N				White			
12 b	n 72 ho e. an "na Medio	mple	(Specify only highest gra		(Give	dent's Usual Occu kind of work done OO NOT use retired	pation during most of work ()	ing	16b. Kind of Business				
25	d withi	Č C	Elementary/Seconday (0-12) 8th		Но	memaker	1		Own	Home			
둤	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)	Albert Pizew	oznik		1	me (First, Middle, Maiden Surname) Cephania Yasick					
Blanclu	2 shouth and the and the street of the stree		19a. Informant's Name/Relationship (Ty Sammy S. Zambell			ing Address (Street Bon Air			r, City or Town, State, Z imore, Mary				
3/2/ ore,	1 and of Heal item		20a. Method of Disposition	20b	. Place of Disp	osition (Name of matory or other pla	!	Date	20c. Location - City o				
timo	t. Page trment o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	v) G		en Mem.		14/2011	Glen Burn	ie, Maryland			
Bal	permit. Page 1: Department of P Important: If it any injury or of		21. Signature of Funeral Service Licens	mones	unh	€. Name and Addr	· G		neral Servi <mark>ltimore, M</mark> a	ce, P.A. ryland 21225			
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only on		ath. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death			
6	nysician , Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	equency of):	Emplyie	110-			Onset and Boarn			
	Examiner	<u>.</u>	Sequentially list conditions,	b. COPE)	5.00 AR							
727	rted d ansit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a conse	iquerice vi).								
MD.	s be executed ysician and e burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a conse	equence of):								
760	cate be physici the bu			d									
к 6876(n certific ending	an/M	20b. Was decedent pregnant	23c. If yes, outcome of preg 1 Live Birth 2 Fe		☐ Ectopic pregnar	ncv		23d. Date of de	elivery			
. Box	the att	ıysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time og ☐ Unknown		Other (specify)			Month	Day Year			
, P.O.	ss that thigned by	Completed by Physician/Med	Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cause g	iven in Part I.		obacco use contribute t	o the cause of death?			
ords	requir been s should	letec						24a. Was		utopsy findings available			
3ec	The law ate has bage 2	omb						autop	osy prior to ormed? death?	completion of cause of			
[a]	sian; artifica	Be	25. Was case referred to medical examiner?				Place of Death (Chec		-/				
Ž	Physia this o	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 [28a. Date of injury	ER/Outpatie	nt 3 LI DOA			dence 6 Other (Spe	city) HOSPACES			
o uo	ending eath. or: After he funer	Certificate:	Natural 5 Pending Accident Investigation Suicide 6 Could not by	(Month, Day, Year)	ry at rk?] Yes 2 □ No	28d. Describe how injury occurred							
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (S City or Tow	Street and Number or Ro vn, State)	ural Route Number,			
	e Hospi 124 hou e Funer	Medical		sician: To the best of my kno ner: On the basis of examinat te Practioner: To the best of									
	To the within To the comp	2	29b. Signature and title of certifier		,	29c. Licens		T	29d. Date signed (Mont				
	}		lele	LISO.		}	40064267 1-10-11						
	5		30. Name and address of person who o	ompleted cause of death (Ite	em 23a) (Type,		2 Av Sali	5 ×210.2	1.701				
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1 1 2011	32. Registrar's Sign	pature		- 110						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00388 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Zabetakis Thomas 8:55P M 01 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2403 Forest Edge Court Anne Arundel 0denton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min Director 80 PA 166-24-8269 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔯 No Maryland Anne Arunedel 0denton 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 2403 Forest Edge Court Unit F 21113 U.S.A. or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1

Yes 2

No If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced 4 Divorced Completed Year or Dates. White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Engineer Specialist</u> Federal Government be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John E. Zabetakis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Julia Popeck 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Catherine Zabetakis 2403 Forest Edge Court Unit F Odenton MD 21113 20a. Method of Disposition Jan _{Date} 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place 2011 Meadowridge Mem Park Elkridge, MD Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave Sw Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ men disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 LNo 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has ' page 2 s autopsy certificate ! 2 No Yes -1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 6 Other (Specify) 27. Manner of Deati 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury 1. Natural 5 Pending 24 hour after death. Funeral Director: Al 2 🗆 No 2 Accident Investigation in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completed fille Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my calculated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

18 45 31. Date filed (Month, Day, Year)

JAN I I ZUIT

Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LTIMORE 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday Funeral Min. 1 ₺ M 2 🗆 Hours 66 Director 225-66-7906 1944 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No Page Luray VA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 22835 Cattail Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Master Blaster Demolition Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Josephine Laura Irey Paul Jay Bradt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 22835 VA <u>Judith Ann Bradt</u> - Wife Cattail Lane, Luray, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite ō 1 🗌 Burial 🔾 🖾 Cremation 3 🗀 Removal from State Harrisonburg Cremation injury o 4 Donation 5 Other (Specify Jan.12,2011 Harrisonburg, VA The Bradley Funeral Home, 22. Name and Address of Facility
187 E. Main St., PO Box 442, Luray, VA neral Service I Inse 21. Sign ture of FV Þ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ brain disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of): To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 1 Tyes 2 🗌 No death. 2 Accident
3 Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital or within 24 hours aft To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ceatri occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LACKMO D ULIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harwood Anne Arundel Mandrin Hospice House 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 10-30-192 Director 83 146-22-1669 Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified i NJ Passaic Paterson 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 257-East 28 Street 07514 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 XNo Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: African-American 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th New Jersey Bell-Verizon Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Issac H. Bowles Ella Weeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 257 east 28th Street, Paterson, NJ 07514 Thomas S. Blackmon Sr./ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or 1 X Burial 2 Cremation 3 Removal from State George Washington Memorial 1-21-2011 4 ☐ Donation 5 ☐ Other (Specify) Paranus, New Jersey 22. Name and Address of Facility 200 Liberty Road, Randallstown, MD 21133 ure of Funeral Service Licenses Wylie Funeral Home P.A. of Baltimore County 23a. Part 1 Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D. ath Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Duc to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred PLCÉ 5 \square Pending 1 Natural trust __ Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Lecritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier a wo completed dause of death (Item 23a) (Type, Print) ne and address of person who NAM 441 le 6 1. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

1 2 2011

Registrar
DHMH 17 Rev 7/2009

11-00255 Karla M Butler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 9, 2011 0414 hrs Medical Examiner Karla Michelle Butler 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4019 Shannon Drive Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Davs Hours Director 2 X F 219-04-0655 1 M 43 11-13-1967 DC. Usual Residence of Decedent 10d Inside City Limits iny 10a State 10b County 10c. City. Town or Location 1 X Yes 2 No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nient of Health and Mental Hygiene.

Mart. If item 27 is marked other than "matural", or items 23a or 28a-f show to the traumatic event, the Medical Examiner must be notified at once. Director n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 4017 Shannon Drive USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes Specify: African-American 3 Widowed If Yes, Give Yeer 1 Yes 2 No specify: 4 Divorced the Medical Examiner 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036 GVA** Future Care 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hermena B. Henegan James Edward Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Hamiliton Avenue, 1st Floor, Baltimore, MD 21214 Donte Thampson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 T Cremation 3 Removal from State 1-12-2011 Metro Crematory Baltimore, MD Donation 5 Other Specify 22. Name and Address of Facility 9200 Liberty Road, Randallstown, 10 2113 21. Si nature of Funeral Service Licens Wlie Funeral Home P.A. of Baltimore County Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and e. List only one cause on each line. /Medical Death a. Smoke Inhalation and Thermal Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical g physician a AMENDED UNPENDED Records. P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the y the attending p hed for use as th Day 1 Live birth 3 Ectopic pregnancy Month Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown this certificate has been signed by the I director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 ✓ Yes 2 No 3 Probably 4 Unknown Cardiomegaly, Obesity Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26 Place of Death (Check only one) Division of Vital examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 2 No 28a. Date of Injury (Month Day,Year) Jan 9, 2011 28c. Injury at Work 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: victim of house fire 1 Natural 0237 hrs 1 Yes 2 ✔ No Director: d in by the Pending within 24 hours after death. To the Fuoeral Director: 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4019 Shannon Drive , Baltimore, MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 9, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)

JAN 12 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10 per fh g912 2-11-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Daγ Physician/ Month 8:30 AM January 10, 20 Joan O'Conner Barchus Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1331 Poplar Hill Drive Annapolis A.A. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕽 F Days (Month, Day, Year) May 15, 1927 Months Hours 83 Eng Land Director 467-42-3759 Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD. A.A. Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 United States 1331 Poplar Hill Drive death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. o. 1 Never Married 2 Married Completed by 72 hours after ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: marked other than "natural" 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) uld be filed within I within DU: N HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Denis O'Connor Emily Williams other traumatic . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Wallace /Daughter 1313 Poplar Hill Drive, MD 21409 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Important: If it any injury or o 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Jan 11 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Ovarian disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical # المارية الم as 1 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 40005554 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 1 8 31. Date filed (Month, Day, Year)

JAN 12 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perINF, G912, 2/2/2011 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald James Baker, 755 AM 03 2011 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA Good Samaritan Hospital Baltimore Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) 70 Yrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** $\frac{217-38-5064}{217-38-5464}$ 1 🔀 M 2 🗆 F Director 1940 show 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a MD NΑ Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1229 Meridene Drive 21239 USA ral", or items? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No If Yes, Give be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced 4 Divorced Specify: Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 7 12th Electrician Bethlehem Steel Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter Alexander Baker Ellen Irene Edmonds other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1229 Meridene Dr. Balto., MD 21239 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Beverly A. Baker - Wife 1229 Meridene Dr. Balto., MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 1/10/11 Woodlawn, MD 4300 Wabash Ave. 21215 Signature of Funeral Service Lice March Funeral Home West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown ate has been signed by the atte page 2 should be detached for Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by METASTATIC COLON CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLITUS 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☑ No Yes 2 No To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mon RES DOD JANUARY 03 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD 5601 RAVEN BALTIMORE MD KUMAR LOCH NIRMAL 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

O

5

01002

0

W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Per fh, g911,01/12/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LAURETTE 2011 JANUARY Ŏ9 4:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8002 BRYNMOR COURT, #302 BALTIMORE BALTIMORE 8. Date of Birt 99/24/1925 g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. ONOPTH-Pay, Year) = **Director** 156-14-4501 85 Usual Residence of Decedent or 28a-f shov notified at show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 Tes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 8002 BRYNMOR COURT, #302 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates WHITE Specify 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EVA ABRAHAM BADESCH SNYDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 BRYNMOR COURT, #302, BALTIMORE, MD 21208 STUART BERGER/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM PK 01/11/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death! Ph sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the officer of the control of the cont cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 1 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manger of Death 28a. Date of injury 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 69 CHARLET ST. BALTIMORE, MD 21268 CONON GARY 65 RI.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

			Regis
I			1. Decede
	Physicia /Medic		Len
	Examin		4a. Facility
			For
	Funeral	4	5. Social S
	Director		232-
	13		Usual Res
	yland		10a. State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryl Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural; or iteme 23s or 28s-f eht en injury or other traumatic event, it is Mazical Examinat must be notified a ont.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - For State Registrer	State of Maryland / D		nent of H		ind M		iene	Part to contain	00395
	1. Decedent's Name (First, Middle, Last)						2. Date of Deat		V	3. Time of Death
n	Lenard Edward C	asey					Month January	9, 201	Year 1	1:40 P M
al r	4a. Facility Name (If not institution, give st		4b.	City, Town, or	Location of			4c. County		
	Forestville Healt	h & Rehab		Fores	stvil:	1e		Princ	e Geo	orge's
	5. Social Security Number 6. Sex	9 . ,		Inder 1 Year	If Under 2	24 Hrs.	8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
	232-70-5415	M 2□F 67	rs.	nths Days	Hours		May 14,	1943	Mary	yland
	Usual Residence of Decedent									
_	10a. State 10b. County	10c. City, Town							1	0d. Inside City Limits
ဥ	MD Prince Ge	orge's Capi		leights						1 ☐ Yes 2X☐ No
	10e. Street and Number		10	of, Zip Code			1	0g. Citizen of \	What Cour	ntry?
8	1700 Ruston Avenu	e		207				USA		
by Funeral Director	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was I If Yes	Decedent of His , specify Cubar	spanic Orig n, Mexican	jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		e - Americ ck, White,	ean Indian, etc.
Σ Σ	1 ☐ Never Married 2 ☑ Married	1 ⊠Yes 2 □ No If Yes, Give	1 □ Y	es 2 X No	Specify:			Specify	: B1a	ack
0	3 Widowed 4 Divorced	Year or Dates:								
Completed	15. Decedent's Educ (Specify only highest grade		(Give kind	Usual Occupa of work done d OT use retired;	uring most	of worki	ng	16b. Kind of B	usiness/In	dustry
ב	Elementary/Secondary (0-12)	College (1-4or 5+)		,				7		_
	12 17. Father's Name (First, Middle, Last)		Labor	er	18 Mother	r's Name	(First, Middle, I	Constru		1
Re							annie L		,	
0	William B. Casey 19a. Informant's Name/Relationship (Typ)	an Deinell 10h	14-11 4-d	d (C)						- C- d-1
							I Route Number			20743
	Annie Casey - Wif 20a. Method of Disposition	e 20b. Place of			avenu		apitol 1	16 Ignus 20c. Location -		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	y, cremator	y or other place	1					
	4 Donation 5 Other (Specify)		_	lemoria:	-			Chatha		A
	21. Signature of Funeral Service License	8)	22. Nar	ne and Addres	s of Facility		iller F			SSE TOPPENDEN
	23a. Part1. Enter the disease, or complic	nuce	[tna,	VA 24557 Approximate
cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):				ciden			
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	pic pregnancy er (specify)			23d. Date of delivery Month Day Year					
7	Part II. Other significant conditions cont	inbuting to death but not resulting in	the underly	ing cause give	n in Part I.		23e. Did tot	acco use cont	ribute to th	he cause of death?
	Algheimen	Domen Tiz					1 □ Ye	s 2 No	3 ☐ Prob	oably 4 🖃 Unknown
<u>ĕ</u>	to states	Mell, The					24a. Was a	n 24b.	Were auto	ppsy findings available
Ē	•0	112111111111111111111111111111111111111					autops	ned?	prior to co death?	mpletion of cause of
	25. Was case referred to medical				00 Bl	-4 D4b			1 ☐ Yes	2 No
0 00	examiner?	ospital: 1 Inpatient 2 ER/Out	antinat Of	DOA Othe	-	_	(Check only on		(0	
0	27. Manner of Death		ime of	28c. Injury Work		-	ne 5 🗆 Reside			у)
9	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Ir	njury N		? ′es 2 □ N			, ,		
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Boute Number)									al Route Number.	
eLI	4 ☐ Homicide determined	building, etc. (Specify)	., 5., 500, 11	7, 5.1100			City or Town			
<u>ء</u>	29a. Certifier 1 Certifying Physi	icien: To the best of my knowledge	, death occ	urred at the tim	e, date and	d place :	and due to the o	ausa(s) and m	anner as s	tated
Š	(Check only 2 Medical Examinone)	er: On the basis of examination and manner stated.	d/or investig	ation, in my op	inion, deat	th occurr	ed at the time, d	ate and place,	and due to	the cause(s)
Š	29b. Signature and title of certifier			29c. License	number		2	9d. Date signe	d (Month.	Day, Year)
	13. 11			12	90	93		01-10		- 1
	20 Name and address of the control of	malatad annua of death (New 2001)	Time Orbit		, ,	٠, ر		1 6	7	017
	30. Name and address of person who con			outhe	0 21	Δ	0.	De	20	032
	31. Date filed (Month, Day, Year)	32. Registrar's bignatur	100	DU 1 7e	N.	1101	3 =	UC	7	32
r	JAN 1 2 2011	Denews B. Loan	Car							

DHMH 17 Rev 1/2001

Stat

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00396 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month January 2019 4:32 p. Ruby N. Carlton Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death n/a Baltimore Sinai Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD 1 □ M 2 🗓 F Hours Min. 10-30-7935 **Director** 215-28-2127 Usual Residence of Decedent 10b. County 10a, State 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 Yes 2 No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 Howard Park, Apt. 311 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Yes 2 X No þ 1 Never Married 2 Married Specify: African-American If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Childrens Hospital <u>Dietician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Solomon Kellum Ruby McNeil 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Taylor/Sister 12366 Bonfire Drive, Reisterstown, MD 21136 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 1-15-2010 King Memorial Park Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 2113-21. Signa are of Funeral Service Licensee Wylie Funeral Home P.A. of Baltimore County 23a. Part/1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). nemic attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 LNO this certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opiniori, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier M-D D607007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste Parkuille, MD-21234 RA 3 walthan woods 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 2 2011 Registrar

DHMH 17 Rev 7/2009

Neger

Known RS;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Cain January 08, 2011 4:30 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard County 3561 Centenial Lane g. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours (Month, Day, Yea Dec. 24, 1941 213-82-0770 69 Maryland Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Maryland Howard County Ellicott City 10e. Street and Number 10g. Citizen of What Country United States items 23a 3561 Centenial Lane 21043-4807 America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 X Never Married 2 ☐ Married permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin ☐ Yes 2**X**No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Specify Completed Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dawson Mary Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2822 Hollins Ferry Road Baltimore, Maryland 21030 Joyce Cates/Representative 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 4 Donation 5 Other (Specify) 14, 2011 Landsdowne, Maryland 21. Signature of Fun Al Service Lipersee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Chemation Center, P.A.
2325 York Road Timonium, Maryland 21093—2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) BRAIN SYNDROME Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 × No Yes 1 🗌 Yes 8 B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined e Funeral C 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, deathloccurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 5122 2011

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 30 per verb., d9171927261 Health and Mental Hygiene Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 6130 Physician/ Ohn 201 Medical 4a. Facility Namerif not institution, give street and number) **Examiner** Jown, or Location of Death 4c. County of Death Hos Harver Baltmore -Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F Days Hours 215-54-9442 Months 67 Director PA Nov 18, 1943 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **Baltimore City** 1 ☐ Yes 2 No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3300 Wilkens Ave 21229 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Midowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Civil Servant** Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Clinton Hughes Chase Catherine Laugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Chase son 8713 Cheshire Ct. Jessup, MD 20794 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **Good Shepherd Cemetery** Jan 06, 2011 Ellicott City, Maryland 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 a relof Furieral Scrvice koe SIL 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Se Physician/ disease or condition Medical resulting in death) Due t (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending hours. Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi also Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Day Year 9 Unknown P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag. 2 🗆 No Yes 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ ØOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident
Suicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) 01,02 RES OU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Marker, M.D., 3001 S. Hanover St., Baltimore, MD 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year Month Norman Davis 2011 12:00 pM Medical Tan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Med. Glen Burnie Ctr Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, 1 X M 2 🗆 213-64-2940 **Director** 53 Jan. 16, 1956 Maryland Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Anne Arundel Dorsey 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral 21076 1582 Abraham Road USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black White etc. 1 Never Married 2X Married by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: 'natural", Specify: Completed 3 Widowed 4 Divorced Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel Co. 27 is marked other than traumatic event, the Me 9th Grade Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) Janitor School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wade Davis Mamie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Consuella H. Davis/ Wife 2550 Lauretta Avenue Baltimore, MD 21223 permit. Page 1 and 2:
Department of Health
Important: If item 27
any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemeter, crematory or other place)

Carmel Cemetery 1/10/11 1 X Burial 2 Cremation 3 Removal from State Mt. Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 TXa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nllalu Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the bunal-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this control of the Funeral Director and the state of the funeral Director and the state of the funeral Director and the state of the funeral Director and the state of the 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page ≥Z No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 063726 Œ rson who completed cause of death (Item 23a) (Type, Pript)

Registrar

State

30. Name and address of p

31. Date filed (Month, Day, Year)

1406

crain

32. Registrar's Anature

ma

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:26 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City **Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec. 6, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🛣 F 79 215-28-6000 Yrs. Ĩ′931 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or Items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 No Director |Maryland|Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7501 Furnace Branch Rd., Apt. C 21060 United States Funeral death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Ite Lry or other traumatic event, the Medical Examiner 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: ģ 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Virginia Arnold William Davis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Howard / Nephew 8103 Fruitful Ct., Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Brooklyn Park, Maryland 4 Donation 5 Other (Specify) of Funer | Gervic Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, 21. Sign MD 21061 8 23a. Part N. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intracerebral honorhage disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown β 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe certificate has director, page 2 2 No 2 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ည this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation After 1 Natural Injury 2 🗌 No 1 Tyes 2 Accident rector: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide the Hospital 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi Medical (check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 ATTE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Rahimi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Fields, Jr.		- For State Registrar	S	tate	of Maryla	and /	Departm <i>Certific</i>		Health ai <i>Death</i>	nd Mer	ntal Hy		leg. No	. 2011	0040
Physician Medical Examine	/	1. Decedent's Name James Alle					-				1	2. Date of Dea Month	ath Day	Year	3. Time of Death 0234 hrs
wiedicai Examine	٠.	4a. Facility Name (i				ımber)		4	b. City, Town, o	or Location	of Death	January 5		11 tc. County of Dea	
		Northwest F		-					Randallsto	own				Baltimore Co	unty
Funeral Director		5. Social Security N 220–88–6318		6. Se	х М 2F	7. Age (In yrs. last birl 47	hday) Yrs.	If Under 1 Ye Months Da	_		8. Date of Bi	·	//DD/YYYY) 9. B Fore C	
h	L	Usual Residence of	Decedent			Liz						7 0 13			10d. Inside City Limits
- H	ı		10b. County	7.5		110	Oc. City, Town								1 Yes 2 X No
TLZO the Maryland a or 28s-f show tiffed at once. Director	-	MD 10e. Street and Nur		altir	more		Gwy	nn Oal	10f. Zip Code			1	l0g. Ci	itizen of What Co	untry?
742 (ith the Marylan 13a or 28a-f si notified at one al Directo	6	321 Minika	Place,	Apt.	. 301				2120	7				USA	
er death with 1		11. Marital Status 1 Never Marrie	ed 2 XM	arried	12. Was Dec Armed Fo	orces?_	ver in U.S.		Decedent of H s, specify Cuba)~	14. Race - Ame White, etc.	rican Indian, Black,
s after or iner miner m		3 Widowed			If Yes, Give Yea or Dates:	ır]	Yes 2 N						rican-American
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		15. Decedent's Ed Elementary/Seco			y highest grad College (1			Decedent during mo	s Usual Occupa st of working life	ation (Give e. DO NOT	kind of wo	ork done d) N/a	16b.	Kind of Business	/industry n/a
003(within giene. Medic		11th 17. Father's Name (C							40.14-11-	d- N ()	First Baidala I	1	. (
215- be filed ntal Hyg rked off		James A. F									,	First, Middle, I • Folks	walder	n Surname)	
21, hould be not Men is maritic ever	: [⁻	19a. Informant's Na			pe, Print)									City or Town, State	
, ME and 2 s ealth a tem 27 trauma	L	Tina S. Fie	-	це					OLILKA FL		_	Date		k, MD 2120 Location - City o	
More		1 Burial 2 Donation 5			Removal fr	om State	Metro	ory or othe Cremat			L-14-2	011	В	altimore,	MD
Caltir Trmit. I Spartm Sports jury of	1	21. Signature of Fur	neral Service	Licens	ee		I						Roa	d, Randail	stown, MD 2113
ப கத்தத் Physician		Sa. Part I. Enter the	e disease, or	compli	cations that ca	aused the	e death. Do no		e Funera		_				Approximate Interval
/Medical		failure. List on! Immediate Cause (f	y one cause	on eac						,,		- ,	,	,	Between Onset and Death
Examiner		or condition resultin			ue to (or as a	consequ	ience of):	ostin	g Quadi	einlo	oi o				
ē		Sequentially list cor f any, leading to im	mediate	b D	ue to (or as a			Call	g Quau	трте	дта				
ted Insit	1	cause. Enter Under Disease or injury the events resulting in o	nat initiated	c.	Remot			Jound	of Bac	ck		-			
		events resulting in c	Jeanny Last	d	,		,								
0, be ex sician surial	L	X UNPENDED						11,2	7,28a-f	per	me g	912 2-1			
). Box 6876C the death certificate by the attending phys ched for use as the bh Physician/Me	2:	F FEMALE: 3b. Was decedent p past 12 months		ie	23c. If yes, o		of pregnancy 2	Feta	I death 3	Ectopi	ic pregnanc	;y	23	3d. Date of deliver Month	y Day Year
OX 6 eath cell attendifor use		Yes 2 N		nown	4 Pregn		ne of death 5	Othe	er (Specify)						
1 8 8 8 10 10 10 10 10 10 10 10 10 10 10 10 10		Part II. Other signif	icant condit	ions (ut not resulting	in the un	derlying cause	given in Pa	art I.	23e. Did to	bacco	use contribute to	the cause of death?
s, P.(ires that is signed d be dett		Нуре	rtensi	on,	Diabe	tes,	Cereb	covas	cular A	Accid	<u>ent</u> s			✓ No 3 Pro	pably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staffer death. 14 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P												24a, Was autop			itopsy findings available completion of cause of
	L	F 141-							00 Di-	1 D 11	(0)	1 Yes	2 N	1 Y	es 2 No
Vital I sysician: this certifi director,	ľ	5. Was case referred examiner? 1 Yes 2	ed to medica	-	ospital: 1 🗸 la	npatient	2 ER/Ou	tpatient		Other ₄	(Check on Nursing		Reside	ence 6 Othe	r:
of Viting Physical After this Tuneral dir.		7. Manner of Death			28a. Date (Month,	of Injury Day,Year)	28b. T	ime of Inj		ıry at Work		8d. Describe h	now inj	jury occurred	_
Sion Attendi death ector: by the f	1	1 Natural 2 Accident	5 Pend Inves	ling stigation	1	0-92		1:36	Pm	Yes 2 X				as shot	and Davids Number City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director, ledical Certification: To Be (١.	Suicide Market Suicide		d not be mined	(Specify)		ore	m, street,	factory, office	building, et	B	or Town, S	tate)	1919 Gre	ral Route Number, City enmount Ave
To the How within 24 h To the Fun completely	(miner:		f examina								nd manner as stat ace, and due to th	
F 3 F 3	2	9b Signature and	itle of certifie				post	20	29c. Licens					Date signed (Mo	
		(well	25/	M	E 5/	ell	h /lharr on :	_	O.C.	M.E.			Jan	nuary 11, 201	
		0. Name and addre Victor Weed	n MD JD		sistant Med	dical Ex	xaminer	900 W.	Baltimore S	Street, B	altimore	, MD 2122	:3	·	
State Registrar		1. Date filed (Month	1 2 20	11	32. Re	gistrar's S	Signature	ار محمد رہ	,						
DHMH 17 Rev 1/2001			0	CME	- Company		ORI	GINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ +:0Medical Facility Name (if not institution, give street and number) Examiner or Location of Death County of Death Baltimore If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 💢 F Min 0972271958 **Director** 52 214-84-7376 MD Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4601 TALLMAN ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc ō þ 1 XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: "natural", 3 Widowed 4 Divorced Completed WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natur any injury or other traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NONE NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ ELLIOTT FRIBUSH LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN FRIBUSH/MOTHER 35 STONEHENGE CIRCLE, #1, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HAR SINAI CONGR. 01/11/2011 OWINGS MILLS, MD Signature of Funeral Service Licent 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (o as a consequence of) Exåminer Sequentially list conditions, if any list limit of the cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 🗌 Yes 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🕱 No Be 26. Place of Death (Check only one) Hospital Other: ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a (Item 23a) (Type, Print) on who completed 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16a, perFH, G911, 1/12/2011, WS

State of Maryland / Department of Health and Mental Hygiene 00403 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GILLIAM Month 2011 Physician/ 3:15AM January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Future Care - Irvington NA 13a Himbre 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month Day, Year) Country) NC Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Baltimore Examiner must be notified MD andallstown 1 🗆 Yes 2 🗙 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 304 Templar INSA , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BACK Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Steel Worker (Specify only highest grade completed) Steel Elementary/Seconday (0-12) College, (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F th and Mental P 27 is marked of traumatic eve Grant Gilliam Lascoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trausonce. Road Randall stown MD 21133 Grant Gilliam / 3604 Templar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🕽 Cremation 3 🗆 Removal from State 01/17/2011 Baltinone, MD zveenmount Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vauann C. Greane Funeral Services 22. Name and Address of Facility augh 728 Liberty Road fandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DECUBITI - INFECTED Pnysician/ Medical MULTIPLE disease or condition resulting in death) TWO MUNTH Examiner PERIPHERAL SEVERAL YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) YPE DIABETES MELLITUS SEVERALYEAR that the death certificate be executed the bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ESSENTIALHYPERTENSION Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown Completed ADVANCED DEMENTIA WITH MOOD AND BEHAVIORA 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DISTUR BANCES performed? Yes 2 N HYPERLIPIDEMIA. 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 1 ☐ Yes 2 X No 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier Ravy 29d. Date signed (Month, Day, Year) DO018362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455, Wilkens Ave Battimore, Md 21229 Komal K. Dang M.D. 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

			For State	State of Ma		id / Depa	artment o	f Health	and I			-	00404
			Registrar 1. Decedent's Name (First, Middle, Las	4)		Cel	tificate o	T Deatr		T. de de	Reg. No.	_	
	Physicia Medic		William J	anes	(SUN	rer			2. Date of De Month	Day	K Year 201	3. Time of Death
	Examir	er	4a. Facility Name (if not institution, give	street and number)	s Ni	tal	4b. City, Town	n, or Location			10 (ounty of Death	~
	Funeral Director		444-26-1071	N7	(In yrs. I 8 1	ast birthday) Yrs.	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Bi (Month, D	rth ^{gy, Ye} ar) • 192	9 0k 1	place (State or Foreign htry) anoma
	yland f show ed at	tor	Usual Residence of Decedent 10a, State 10b. County		10c. Cit	y, Town or Lo					-		10d. Inside City Limits
	he Mar or 28a- or otifii	Direc	MD Balt:	imore		Owing	10f. Zip Cod				10a Citizer	n of What Cou	1 🗆 Yes 🗶 No
	h with t ns 23a nust b	Funeral Director	17 Walk Ave.						117			U.S.A	-
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes XX	er in U.S No		Vas Decedent of Yes, specify C			ecify Yes or No Rican, etc.)		Race - Americ Black, White,	etc.
2-00	hours an atural	leted	XX Widowed 4 ☐ Divorced	Year or Dates.		16a. Deced	lent's Usual Occ	cupation				of Business In	hite
21215-0036	ithin 72 ene. • than "I he Mec	Completed by	(Specify only highest graves Elementary/Seconday (0-12) 1 2	de completed) College (1-4 or 5-	-)	life. D	kind of work dor O NOT use retire Lectric	ed)	ost of work	king	1	lectr	
	filed wi al Hygie d other	Be	17. Father's Name (First, Middle, Last)			_ E.J	eculi	18. Mo		ne (First, Middle	, Maiden Sun	name)	
Maryland	ould be d Ment marked matic e	٦	E1mer M. Gund			T				Be 11			
	nd 2 shc ealth an m 27 is ier trau		Penny Zagami ,	, ,	er		g Address (Stre Powers					· C · 2	
Baltimore,	age 1 al ent of H nt: If itel y or oth		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐		20b. P	Place of Dispo emetery, cren Vergr	sition (Name of natory or other p een 1 Gard	olace)		Date 4/11		ion - City or To	
altir	permit. P Departme Importar any injur		4 Donation 5 Other (Specifical Signature of Funeral Service License)		l Me	22	. Name and Add	dress of Fac	Eck	hardt	Funer	al Cha	pel P.A.
	9 9 E 8 9		23a. Part 1. Enter the disease, or comp	Murus that assured	the death							gs Mil	1s,MD2111
	Physician/ Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	<i>چ</i> دا	entic	^	@/Q/			۵،50	se	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a	оставци	refice of).			-	350			
) \$ -	executed an and ial-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequ	ience of):							
092	physicia the bur	edical		d									***
. Box 6876	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Feta	Ideath 3	Ectopic pregna Other (specify)				23d	. Date of deliv Month	ery Day Year
, P.O.	ires that th signed by d be detac	by Ph	Part II. Other significant conditions co	ntributing to death bu	t not res	ulting in the u	nderlying cause	given in Pa	rt I.				ne cause of death?
ords	require been si should	leted							-	1			bably 4 Unknown psy findings available
Reco	sician: The law certificate has l lirector, page 2 s	Completed by								auto		prior to co death? 1 Yes	mpletion of cause of
/ital	sician; certifi	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			1/10	Place of De					
n of \	ding Phys th. After this funeral dii	cate: To	27. Manner of De th 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,		ER/Outpatien 28b. Time of injury	28c. In	jury at ork?		ome 5 Resi)
Division of Vital Records,	I or Atter after dea Director d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined							ımber or Rurai	Route Number,		
7	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier 1 Sertifying Phys (Check only one) 3 Certifying Nurs	ician: To the best of mer: On the basis of exa	mination	and/or investi	gation, in my op	inion, death	occurred a	the time, date a	and place, and	due to the car	ise(s) and manner stated
	To the within 2 To the comple		29b. Signature and title of certifier		IIIy	.a.o.wouge, u	29c. Lice	nse number		, and due to th		gned (Month,	
			30. Name and addless of person who co	C	th (Itom	23a) /Tupo D		056	1 30)	Junv	y 11t	2011
	5		holney bishow	MD: 5	114	010		-200	Ld	Dadall	j rawn	hay	lad 21133
40	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar	s Signat	ha K	9					1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 Day 10 2011 02:00 Anna Green Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 6. Sex 1 ☐ M 2 💢 F If Under 24 Hrs Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days 0471371915 95 Yrs. **Director** 215-03-8494 MD Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 28a-1 1 Tes 2 X No MD MD Baltimore ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 5352 Perring Parkway 21239 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force . or Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1

☐ Yes :

If Yes, Give 1 ☐ Yes 2 💢 No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than * Elementary/Seconday (0-12) College (1-4 or 5+) 6 Seamstress Tailoring 8e 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evenone. ၉ Francisco Lentina Borsella Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Borsella, Daughter 5352 Perring Parkway, Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🕱 Other (Specify) Entombment Dulanev Vallev Memorial 01/15/2011 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition DEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 2 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has b irector, page 2 s performed 2 🕱 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: မြ 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) elea 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month) Year) 4 2011 32/Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

2:00

JANUARY

cura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yea Month M Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (if not institution, give street and number) Examiner Baltimore City 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Apr. 3, Days Hours Min. 1 □ M 2 🖾 F Mary Tand 219-10-4982 84 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2 No Glen Burnie Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō or Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a United States Funeral 21061 401 Melrose Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married þ 1 Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify. White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Distillery Assembly Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I important: If item 27 is marked o any injuy or other traumatic evenones. မှ Mae (unk.) James J. Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 220 Kueths Rd., Glen Burnie, Maryland 21060 Francis Joseph Griffith / Son Date 15, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Jan. 2011 1 XBurial 2 Cremation 3 Removal from State Brooklyn Park, Maryland Cedar Hill Cemetery 4 Donation 3 Other (Specify) Name and Address of Facility irkley-Ruddick Funeral Home, P.A. 21 Crain Hwy., S.E., Glen Burnie, 21. Signal re of Properal Service Licerses 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Ischemic Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Month Day in the past 12 months? Pregnant at time of death g 🗍 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 1 TYes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA 2 👿 No 1 Tes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29b. Signature and title AU4176B5B18850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST Baltimore Jennifer 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Gray Michael 2011 January 9 3:30 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico 20502 Nanticoke Road Nanticoke Social Security Number 6. Sex Age (In yrs. last birthday) 78 Yrs. **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) England Months 159-44-0632 Hours 1 XM 2 🗆 F 14/03/1932 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Nanticoke Wicomico Yes 2 No 10f. Zip Code 21840 5 10e. Street and Number 20502 Nanticoke Road 10g. Citizen of What Country? 23a Funeral items death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0 ģ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Precious Metals Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Doris Lucas Thomas Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre 23661 s (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Taylors Trail, Mardela Springs, MD Adam B. Gray / Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 1/14/2011 Woodbine, MD Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland PO Box 1 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Ondet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Communitable fet may the com-Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ľo Month Day Year by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 100 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) within 24 hours after upour.

To the Funeral Director: After the 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and

CARROLL

who completed cause of death (Item 23a) (Type, Print)

1 40

20507

29d. Date signed (Month, Day, Year)

SACKBURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Î1, 20Î1 JANUARY 8:30 A M SYLVIA GHITMAN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A 2104 NORTHCLIFF DRIVE Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) TST 1 □ M 2 🛛 F Days Min. Hours 06/07/1926 NY 092-18-5645 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No BALTIMORE N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 2104 NORTHCLIFF DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LOUIS SILBERMAN REBECCA KOPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 NORTHCLIFF DRIVE, BALTIMORE, MD 21209 LOU GHITMAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) PLEASANT CEMETERY 01/11/2011 HAWTHORNE, NY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of):

Physician/ Medical **Examiner**

sician and burial-trans

that the death certificate be executed

Box 68760

Division of Vital Records,

Hospital or Attending Physician: The law requires

after death Director: / in 24 hou. the Funeral Dire. ∼4 filled in by th

To the I within 2

Examiner

Physician/Medical

ò

Completed

Be

မ

Certificate:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

For State

10a. State

MD

Director

Funeral

ģ

Completed

Be

2

Physician/

Medical

Examiner

Funeral

Director

or 28a-f shov

be notified

ed other than "natural", or items 23a event, the Medical Examiner must b

is marked other

permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

9 Unknown

2:	Bc. If yes, outcome of pregnancy
	1 Live Birth 2 Fetal deat
	4 Pregnant at time of death
	a linknown

h	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ERTENSION

23e. Did tobacco

	tribute to the caus	
2 🗌 No	3 Probably	4 Unknown
T		

1 🗌 Yes 2 [□ No 3 🛎	Probably	4 Unknow
24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were a prior to death?	utopsy fir completi es 2	ndings available ion of cause of No

25.	Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
27	Manner of Death

		4	26. Place of Death (Chec	ck onl	y one)	
1 🗌 Inpatient 2 🗆	ER/Outpatient	з □ доа	Other: 4 \(\sum \) Nursing H	ome	5 Residence	6 ☐ Other (Specify,
	28b. Time of	28c.			Describe how inj	

	death?	2 🗆 No	
0	T Hes	2 L NO	

7. Manner of Death	
1 Watural	5 Pending
2 Accident	Investigatio
3 Suicide	6 Could not I
4 Homicide	determined

ending estigation	(Month, Day, Year)	injury	М	28c, Inju wo 1 [
uld not be	28e. Place of Injury - At he	ome, farm, stree	t, facto	ry, office

building, etc. (Specify)

Hospital:

	28c, Injury at work?	
М	1 🗌 Yes	2 🗌 No
	· · · · · ·	

28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier	1 de Certifying Physician:	To the best of my knowle	edge, death occured at the time, date and place, and du	ie to the cause(s) and manner as stated.
(Check	2 Medical Examiner: On	the basis of examination	and/or investigation, in my opinion, death occurred at the	time, date and place, and due to the caus
only one) 3 Certifying Nurse Prac	tioner: To the best of my	knowledge, death occurred at the time, date and place, ar	nd due to the cause(s) and manner as state
29b. Signature	and title of certifier	\wedge	29c. License number	29d Date signed (Month Da

iffying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.										
lical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
tifying Nurs	tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
ertifier	\wedge	1 -		29c. License number	29d. Date signed (Month, Day, Year)					
+ /	M K	(10)	MA	D 2 3 3 1 9	Janes II Joil					

ne cause(s) and manner	as stateu.
29d. Date signed (Mo	onth, Day, Year)
Janes 1	11 2011

who completed cause of death (Item 23a) (Type, Print)

Registrar

√X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eugenia S.Hunter Physician/ ам January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Davs Hours Min (Month, Day, Year) 2/10/1944 1 M 2 F 231-60-3315 66 **Director** Usual Residence of Decedent show 10a. State filed within 72 hours atter death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Silver Spring MD Montgomery 1 ☐ Yes 2X☐ No 10f. Zip Code 20905 10e. Street and Number 14840 Fireside Dríve 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14, Race - American Indian Armed Forces Black. White, etc. Ď 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3

Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Government Worker Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname)
Louise McIvor Huff 17. Father's Name (First, Middle, Last) 2 Herbert Felix Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zio Code) 14840 Fireside Dr., Silver Spring, MD 20905 Sara L. Hunter / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State /11/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Serv
PO Box 1413, Baltimore, Signature of Funeral Service License Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Cardiac Shock and Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Multiorgan Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 XNo Month Day Year been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 🗶 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2KXN0 မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 24 hours after deatl 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined City or Town, State) 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practiculer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 6, 2011 D0070797 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mourad,

Sami

M.D.,

32. Registrar's

1500 Forest Glen Rd., Silver Spring,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 3:30 PM 8 20 January Medical <u>Doris Marie Hackett</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Levindale Hebrew Geriatric Center Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 Months Days Hours Min. Director 89 29 215-14-0807 Marvland Dec Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Nes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2434 W. United States Belvedere Ave. Rm. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: "natural", 3 ₩idowed 4 □ Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home other traumatic event, Be Page 1 and 2 should be filed ment of Health and Mental Hyy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Michael Schwartz Pauline F. Laber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Simper /Grand daughter 111 Tredmore Road Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Jan 11 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility M014 Cremation and Funeral Alternatives and 21286 23a. Part 1 Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final Physician/ Due to (or as a consequence of): can disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a donsection of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 000 1 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Isteoporasio autopsy After this certificate has 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) B 2 No Hospital: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of De sh 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 No Accident Investigation 24 hours after deat Puneral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: 7 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29c. License number 29b. Signature ap title of certifier 29d. Date signed (Month, Day, Year,

State Registrar death (Item 23a) (Typg, Print)

32. Registra s Signa

nd address of person who completed cause

			FOI	epartment of Health and M	fental Hyg	iene	
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Deal	eg. No.	3. Time of Death
	Physicia		Margaret Koller Heacock		January	Day Year	1:25 A. M
e e e e e e e e e e e e e e e e e e e	Medic Examir		4a. Facility Name (if not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimor	h
	Funeral Director		100 11 0112	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, August	9. Birt 02, 1917 Ha	hplace (State or Foreign untry) wk Run, PA.
	how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location			10d. Inside City Limits
	Aaryla 8a-f s tified	recto	Maryland Baltimore County Timoni	ium			1 ☐ Yes 2 X No
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 2525 Pot Spring Road unit S209	10f. Zip Code 21093–2778		10g. Citizen of What Co United S	
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show tthe Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
Baltimore, Maryland 21215-0036	s filed within 72 hours tal Hygiene. ed other than "naturs event, the Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation Give kind of work done during most of workir ife. DO NOT use retired)		16b. Kind of Business I	e County
nd 21	ent of the G	Be	17. Father's Name (First, Middle, Last)	lementary School Tead 18. Mother's Name Anna She	(First, Middle, N		Schools
ryla		To.	Joseph Sheroky			-	
, Mal	sh har 7 is trau		·	Mailing Address (Street and Number or Rural 15 Edgarwood Court		City or Town, State, Zip	21131–1711
more	Page 1 and 2 lent of Healt of Healt of Healt on: If item 2 ry or other		1 Agurial 2 Cramation 3 Removal from State cemetery,	Disposition (Name of community of community of other place) Disposition (Name of community of other place) Disposition (Name of community of other place) Disposition (Name of community of other place) Disposition (Name of community of other place)	dan I	20c. Location - City or Woodlawn, M	
Balti	permit. Page 1 Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr.	22. Name and Address of Facility Peaceful Alternatives F		Cremetion Cen	ter,P.A.
	Physician/ Medical Examiner		23a. Part 1. Exter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Left lower lowe		r respiratory arre		Approximate Interval Between Onset and Death
09	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)):			•
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
s, P.O.	ires that the des n signed by the a Id be detached f	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		eacco use contribute to	the cause of death?
Division of Vital Records,	The law require ate has been si bage 2 should I	Completed			24a. Was ar autops perfor 1 \(\sum \text{Yes} \)	y prior to c ned? death?	opsy findings available ompletion of cause of
ta	cian; entifica	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check			
Ž	Physic this cral dir	. To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp 27. Manner of Death 28a. Date of injury 28b. Tin			nce 6 Other (Speci	fy)
o uc	nding ath. r: After e fune	icate	1 Natural 5 Pending (Month, Day, Year) inju	work? M 1 Yes 2 No	.ou. BosonBo no	W Injury Goodings	
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	ı, street, factory, office	28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
_	To the Hospital within 24 hours of To the Funeral I completed filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of my knowledge, de 2 Medical Examiner: To the basis of my knowledge, de 2 Medical Examiner: To the basis of my knowledge, de 2 Medical Examiner: To the basis of my knowledge, de 2 Medical Examiner: To the basis of my knowledge, de 2 Medical Examiner: To the basis of my knowledge, de 2 Medical Examiner: To the basis of my knowledge, de 2 Medical Examiner: To the basis of my knowledge, de 2 Medical Examiner: To the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and the basis of examinat	investigation, in my opinion, death occurred at t	the time, date and	d place, and due to the c	ause(s) and manner stated
	To the vithing community of the communit		29b. Signature and title of certifier Preis CRNF	29c. License number R 04358D	2	9d. Date signed (Month)	
			30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)			
				YEY VALLEY ROAD TIMO	ONIUM, M	ID 21093	
	Stat Registra	re.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	•			

JANUARY 11, 2011

MARGARET HEACOCK

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 VIRGINIA GRACE JERNIGHN 3 45 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital FRANKLIN square Rosedale Baltimore Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F 02/02/1926 Months Days Hours 215-28-7343 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Baltimore Middle River 1 Tes 2 X No 10e. Street and Number 5 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 14 Blinker Court 21220 U.S.A. within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev ပ္ Harry Blakeney Lena Bish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Jernigan (Son) 16 Plateau Road, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) Holly Hill Mem. Gard 01/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 21. Signalure of Funeral Service Leonises Part 1. E. er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc., or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm wate Cause (Final Physician/ Due to (or as a consequence of): dis se or condition sulting in death) Medical Examiner Due to (or as a consiquence of): ARTERY disease Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for 4 ☐ Pregnant 9 ☐ Unknown Month Day Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Stage Penal disease on Hemodialysis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Palmonary Embolism 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No ours after death. eral Director: After this certificate I filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sigi and title of certifie 29d. Date signed (Month, Day, Year) RESUDOO ane 1-11-2011 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Thom p50.1 9000 DIGHE FRANKLIN Square DR Balto ind 21237 31. Date filed (Mont) 12 Registrar's Signature State 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	f Marylar		artment of I		and Ment	tal Hyç	giene	2 2	001.13
			Registrar 1. Decedent's Name (First	Middle I a	ct)		Cer	tificate of L	Death		_	Reg. No.	1 1	00413
	Physici Med		Adolph Jackson January (Day	Year	3. Time of Death	
	Exami	ner	4a. Facility Name (if not ins			/		4b. City, Town, o				4c. County		
	<i>A</i>		SINAI HOS 5. Social Security Number	PITA	- OF BI	ALTIMO	RE	BALTIM	ORE		/	N/A		
	Funeral Director		243-54-172		XCX M 2 □ F	7. Age (in yrs. ii	ast <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under : Hours	Min. 8. Da	ate of Birth flonth 3	Year 1938	9. Birth Cour	place (State or Foreign NC
	w d	٦.	Usual Residence of Deced											
:	V uylan a-f sh ied a	1000	MD	County N/A	Δ		y,Town or Loc altim						1	10d. Inside City Limits
S	or 28	ļë.	10e. Street and Number	11/ 2	.,		artrin	10f. Zip Code		<u> </u>				1X Yes 2 □ No
Ho	with t	Funeral Director	3411 W. N	orthe	ern Pkv	νу.		212	15			10g. Citizen of V US		ntry?
1 P	death items items		11. Marital Status			dent Ever in U.S		Vas Decedent of H	ispanic Orig	in? (Specify Ye	es or No-	14. Race	e - Americ	can Indian,
36	after (ğ	1 Never Married 2		1 Tes	2x No		Yes, specify Cuba		, Puerto Rican,	etc.)	1	k, White,	
< 9	ours atura cal E	Completed	3 Widowed 4 D	Year or Date	Year or Dates.							Bla		
75 215	n 72 } an "n Medi	를		ly highest gr	College (1-	1 or 5 i)	(Give k	ent's Osual Occup iind of work done o D NOT use retired)	ation during most	of working	- 1	16b. Kind of Bu	isiness In	dustry
7 2	l withi /giene rer th	ပ္စြ	11th	0-12)	N/A	4 Or 5+)	Owne	r of Sh	ор			Auto S	Shop	
KNown laryland	be filed antal Hy ced oth	To Be	17. Father's Name (First, M Abraham		Jackson	•				r's Name <i>(First,</i> ylvia	, Middle, N	Maiden Surname,	amb	10
N Z	nd Me		19a. Informant's Name/Re				10b Mailin	a Addraga /Stract						
Σ	nd 2 sh ealth a m 27 is		Sarah Jac				3411	g Address (Street a W • Nort	hern	Pkwy.	Balt	imore,	MD2	1215
PATICAT KNOWN AS ADO Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	nation 3 🗆	Removal from S	20b. P	lace of Dispos	sition (Name of atory or other place	meth	Date 7	/11	20c. Location -		
PATIEN 3altimore	mit. Pa bartme bortani injury		4 Donation 5 0			102		Name and Address						
B -	permi Depar Impor any ir	U	(Xona	u c	· Shu	W	45.	300 Wab		MARC	H FU Bal	INERALF .timore	HOME, M	-WEST D 21215
			23a. Part 1. Enter the dise shock, or heart failure	ase, or comp e. List only o	olications that de ne cause on eac	aused the death h line.	. Do not enter	r the mode of dying	g, such as c	ardiac or respi	ratory arres	st,		Approximate Interval Between
7	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		a. ACU	TE MY	YOCAR	PDIAL	INFA	RCTIOI	V		1/	Onset and Death
200	Examiner		Due to (or as a consequence of):											
54		ner	Sequentially list conditions if any, leading to immediat	e J	b. Due to (o	r as a consequ	ence of):							
	cuted	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	1	c									
	e execian a		resulting in death) Last		Due to (o	r as a consequ	ence of):							
760	icate be executed physician and sthe burial-transit	edical			d								+	
89	certiffind nding use as	Z/	IF FEMALE; 23b. Was decedent pregnar	nt I	23c. If <u>ye</u> s, outco	ome of <u>pr</u> egnan	псу					204 8-11	- () (
30X	death e atte	Completed by Physician/M	in the past 12 months?		4 ∐ Pregna	ant at time of de	death 3 🗌 eath 5 🗍	Ectopic pregnancy Other (specify)	/			23d. Date Mon		ery Day Year
0.	t the d by th stache	Ph	g 🗌 Unknown		9 Unkno									
σ,	es tha signed be de	þ	Part II. Other significant co							23				e cause of death?
rds	requir	eted	CHRONIC OF	3-17	16/1/2	FULFI	ONTRY	DISEA	-3 6-		1 Z Ye	s 2 🗆 No 3	3 🗌 Prob	ably 4 🗆 Unknown
000	e law s has b ge 2 s	dm	INTERSTI	71176	LUNG	- DIS	EASE			24	ia. Was an autopsy perform	v pr	ere autop ior to con eath?	sy findings available npletion of cause of
<u>=</u>	in: Th ificate or, pa	ပ္မွ	25. Was case referred to me	edical				00 PI	10.0		☐ Yes 2		Yes	2 12 No
Vita	ysicia is cert direct	To Be	examiner? 1 Yes 2 No		Hospital:	patient 2 🗆 E	B/Outpatient			(Check only or		nce 6 🗆 Other		
of	ng Ph Iter thi Ineral	ie]	27. Manner of Death 1 Watural 5 🗆 I	Pendina	28a. Date of		28b. Time of injury	28c. Injury work?	at			v injury occurred		
ion	tendia death. tor: At the fu	Certificate:	2 Accident I	rending nvestigation Could not be				M 1 □ Y	∕es 2□N	lo				
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			etermined	28e. Place of	f Injury - At hon I, etc. <i>(Sp</i> ec <i>ify)</i>	ne, farm, stree	t, factory, office		28f. Loc City	cation <i>(Stre</i> y or Town,	eet and Number State)	or Rural I	Route Number,
	lospita L'hours uneral ed fille	Medical	29a. Certifier 1 Cert	ifying Physi	cian: To the bes	at of my knowle	dge, death oc	cured at the time,	date and pla	ace, and due to	the cause	e(s) and manner	as stated	l.
5)	the H thin 24 the F mplete		only one) 3 Cert	ifying Nurse				ation, in my opinior ath occurred at the						
4	5 wii		29b. Signature and title of co		1			29c. License				d. Date signed (*
			Davel	lun	le 1	ND			-00	0	17	ANUARY	1,	2011
Ò			30. Name and address of pe	rson who co				HOSPI	TAI	OF	RAIT	TIMODI	2	
4	Stat	е	31. Date filed (Month, Day, Y			istrar's Signatu		110311	, , ,	01	J17-1	11110101		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Duncan Walter Knott January 2011 Medical 8 6:15 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Nov. 2, 1 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Min Director New Orleans, LA 439-03-9944 93 Nov. Ĩ917 Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits Maryland | Montgomery 1 X Yes 2 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 Golf Estate Drive 20882 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Completed Specify: Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Duncan W. Knott Mamie Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlyn K. Spears (Daughter) 21225 Golf Estate Dr., Gaithersburg, MD 70882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buriol 2 Cremation 3 Removal from State Providence Mem. Park 4 ☐ Conation 5 ☐ Other (Specify) 1/14/2011 Metarie, LA 22. Name and Address of Facility Majestic Mortuary 1833 Dryades St., 21. Signs ture of Funeral Service Livensee New Orleans, LA 70113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death RENAL FAILURE ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CHRONIC ENAL FAILURE Sequentially list conditions, if any leading to immediate Examine Divi to for as a consequence of cause. Enter Underlying attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live retailueal
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 1 Yes 2 9 Unknown Month Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown has been ge 2 should HIPERKALEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea. *** *** After Director: After *** After **** ter **** ter **** ter **** ter **** 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 D34740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT FIELDS, MD: 18109 PRINCE PHILIP DR # 200: OLNEY 2083 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edith Marjorie Kilgore January 10, 2011 1:28 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carrol1 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) pril 25, 9. Birthplace (State or Foreign Days 215-24-9168 1 □ M **X**XF Months Hours Min. **Director** 92 Maryland Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Owings Mills 1 Tes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Bradbury Rd. 21117 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \times Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: XX.Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Lab Technician Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Hi11 Bertha Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Lorenz / Daughter Bradbury Rd. Owings Mills, MD 21117 20 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State cemetery, crematory or other place)
1 Faiths Chapel 1/11/2011 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) remat 21. Signature of Ine Al Servic Licensee 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills,MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ nronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death signed by the attending physician and detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day ₹No Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed s been si should 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? မှ 1 Tyes Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No after death Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practigher: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one within To the è 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Fignatu

			• •	Indelible Ink. Ensure All Copies Are Legible.	
			For	epartment of Health and Mental Hygiene	1416
		_	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death 2. Date of Death	0410
	Physicia Medic	al	Mary Clarissa Kramer	January 8 2011 C	ime of Death
	Examin	er	4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital	4b. City, Town, or Location of Death Baltimore 4c. County of Death	
	Funeral Director		5. Social Security Number 213-30-1342 Usual Residence of Decedent 6. Sex 1	Months Days Hours Min (Month Day Year) Country	State or Foreign and
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director			side City Limits
	e Mar r 28a)ire	MD Balti 10e. Street and Number	more	Yes 2 □ No
	/ith th 23a o st be	ıralı	Toe. Street and Number	1	_
	ems ems	nne	6304 Old Harford Road 11. Marital Status 12. Was Decedent Ever in U.S. 1	21214 United State 3. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indi	
9	fter de samine	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No Specify: Specify:	
215-0036	curs a tural	Completed by	3- Widowed 4 □ Divorced Year or Dates.	Whi	te
5	72 hc n "na Aedic	nple	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	scedent's Usual Occupation 16b. Kind of Business Industry ive kind of work done during most of working 2. DO NOT use retired)	
212	within jiene.		Elementary/Seconday (0-12) College (1-4 or 5+)	rogram Analyst Federal Gove	nment
pu	should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	Be c	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)	
yla	ild be Ment narke	오	John Mitchell O'Brien	Anna Zerhusen	
Maryland	shou h and 7 is m traum			ailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code)	
	and 2 s Health tem 27			2420 Autumn View Way Parkville, MD 21234 sposition (Name of Date 20c. Location - City or Town, St.	ate
Baltimore,			1 Burial 2 Ferenation 3 Removal from State cemetery, of	Jan 10,	
alti	コキャラ		21. Signature of Funeral Service Licensee	<u>Deake Crematory 2011 Beltsville, Marce and Address of Facility Cremation and Funeral Alternatives</u>	aryrand
B	permii Depar Impor any in		Linda Sue Patter	8717 Green Pastures Drive Towson Maryland	21286
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Interv	oximate val Between t and Death
March 1	Examiner		Due to (or as a consequence of): End Stage	Pulniwary Discuse	
8	ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury		
y	be executed sician and burial-transit	cal Exa	that initiated events c. Due to (or as a consequence of):		
09/	ate by	edic	d		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beauties of the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Year
, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. Did tobacco use contribute to the caus 1 Yes 2 No 3 Probably	
ords	requii been should	lete		24a. Was an 24b. Were autopsy find	
of Vital Records,	The law ate has page 2	Completed		autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ N	
ta	ertifica ector, I	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
Ϋ́	Physicia this cert ral direct	: To	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ EF(Outpa 27. Manner of Death 28a. Date of injury 28b. Tim		
n o	ding F th. After funer	cate	1 Natural 5 Pending (Month, Day, Year) injur		
Division	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)	Number,
ă	urs aft ral Di				
	Hosp 24 ho Fune eted fi	Medical	(Check 2 Medical Examiner: On the basis of examination and/or in	ith occured at the time, date and place, and due to the cause(s) and manner as stated. vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ınd manner stated
	To the within To the comp	2			ar)
			Terrance L Saker M.	1 DS857U January 08	7 2011
	Y		30. Name and address of person who completed cause of death (Item 23a) (Typ Terrance L. Balker MI) 56	29d. Date signed (Month, Day, Ye. D 5857 U e, Print) U Coch March Blud Baltinione	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Register's Signiture	,	
	. regioti		White - Lott When - 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day KOZIERACKI ANNA AA -00A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis MultiCare Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 160-16-4511 89 May11,1921 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director MoXyes 2 □ No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 South Rappolla Street 21224-4616 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: Specify Wh<u>ite</u> 3₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Home Maker <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Pisok Mary Zarlinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Kozieracki 7505 Biscayne Bay Blvd. Middle River,Md21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Januarv 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Michael Ukr.Cem 10,2011 |Baltimore,Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. D 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions day leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2: No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Physician;

Funeral

Director

show

ir than "natural", or items 23a or 28a-f s the Madical Examinar must be notified

permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Modical Exalurer must augree.

Physician

/Medical

Baltimore, Maryland 21215-0036

with the Maryland

Examiner Examiner and attending physician for use as the buria Physician/Medical signed by the a d be detached for þ Completed has page 2 s certificate this certific al director, Be Certification: To e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera After 3 Sulcide 6 Could not b 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical

_				20,	Flace of Dea	Check only one)	
Ho	ospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA	Other:	Nursing H	e 5 ☐ Residence 6 ☐ Ott	ner (Specify)
1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M		Injury at Work?	2 🗆 No	d. Describe how injury occur	
3	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fa	ectory, of	fice		f. Location (Street and Numb City or Town, State)	per or Rural Route Number,

9a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	curred at the time, date and place, and due to to gation, in my opinion, death occurred at the tim	ne cause(s) and manner as stated. e, date and place, and due to the cause
9b. Signature a	nd title of certifier	29c. License number	29d. Date signed (Month. Day, Year)

	Saw	Le	M	D		
O. Marsas and a data	. 0 . 0			4 .	 	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Бау, 7:00A.M Physician/ Jamuary 2011 Jr. Konarski, Stephen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk 1705 Rita Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Months Days Hours Min. $No^{Nonth}1^{Day}$, Year 924 Mar Vland 216-16-0986 86 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Dundalk Md. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 2 should be filed within 72 hours after death with th and Mental Hygene. S2 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b. 21222 U.S.A. 1705 Rita Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give Black, White, etc. 1 Never Married 2X Married Ď Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Highway & life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Construction Union Rep 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen A. Witek Stephen Konarski, Sr. 1 and 2 should bot Health and Meinten 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 1705 Rita Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Dorothy T. Konarski/Wife 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State January permit. Page 1
Department of
Important: If it
any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State St.Stanislaus Cem | 10, 2011 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the diseade, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ -0.10~av Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to increase cause. Enter Underlying Examine attending physician and for use as the burial-transit certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Natate Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

of time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Hospital or Attending Physician: The law requires that the death in the past 12 months?
1 Yes 2 No signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellions 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **□**∕No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ြို To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this α completed filled in by the funeral dir After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number D 55171 January 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3023 Eastern Avenue Baltimore, Md. 21224 John, M.D. Dr. Sebastian K. 32 Registrar's Signaty 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January '9', 201'T Sr. 2:00A.M Edward Lask, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1704 Stokesley Road Baltimore Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1**X**□ M 2 □ F Days NOV24 1940 Marryland Director 219-38-7606 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director Md. Baltimore 1 Ves 2 No Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 U.S.A. 1704 Stokesley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Types 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filled within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicaal. 16b. Kind of Business Industry Patapsco Waste Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Water Plant Waste Water Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Elizabeth Wilson Lask Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Page 1 and 2 sh artment of Health a ortant: If item 27 is 1704 Stokesley Road Dundalk, Maryland 21222 Betty Lask / Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January w Crematory 14,2011 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 4 Donation 5 Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disea to or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (o Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Tyes Accident nvestigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check

P.O. Box 68760 Records, Division of Vital rin 24 hours, o the Funeral Discompleted filler Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month. Day, Year) D 48105 2011 January 10, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1576 Merritt Blvd, Ste. 14, Baltimore, Md. 21222 Ujwala Desai, M.D. 31. Date filed (Month, D.) (Marr) 1 2 2011 32. Registrar's Signature State barker Registrar DHMH 17 Rev 7/2009

11-00247 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Terry MacArthur 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 2235 hrs **Medical Examiner** Terry Darlene MacArthur January 8, 2011 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Hours Director Jun. 29, 1954 56 Yrs 2XXF country) Maryland 217-64-6488 1 M Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No Maryland Hampstead Carroll Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21074 4126 Sellman Drive of America Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2XX Married Yes Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 4 Divorced If Yes, Give Year 1 Yes 2XX No specify: Specify: White 3 Widowed ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare 2 Nurse 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) B Charlotte Lorraine Farley <u>Joseph Hayes</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and N Important: If item 27 is n injury or other traumatic 4126 Sellman Drive, Hampstead, Maryland 21074 Randy C. MacArthur (Husband) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date ltimore, All Faiths Crematory 1 Burial 2 Cremation 3 Removal from State Jan. 14, 2011 4 Donation 5 other Specify. Manchester, Maryland <u>& Chapel</u> 21. Signature of Function Service Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Part I. Enter the disease, or comprisations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailure. List only one cause on each line (Medical a Narcotic (morphine) intoxication Death mmediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED AMENDED attending physician or use as the burial 23a.27.28a-f. per ME g913_3/3/11TT IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown detached for 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown should be Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has page 2 s performed? death? Yes 2 V No 1 Yes certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Fuoeral Director: After this certifi 26 Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No Pending Fd 1/8/11 Fd 8:33 AM the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) $4126\ Sellman\ Dr$ 6 X Could not be 3 Suicide (Specify) fd residence Homicide amostead 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number O.C.M.E.

Ourant me youle

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Margarita Korell MD.

and manner stated

29d. Date signed (Month, Day, Year)

January 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

			1 - State of Maryland State of Maryland Registrar		tificate of Dea			giene Reg. No.2 ()	00421
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Dear	th	3. Time of Death
	Medic	cal	Lorraine Joan Miller				Januar		4:55 P.M
,	Examir	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc			4c. County of De	
-	Funeral		5438 Lineboro road, East 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthdav)	Manche	Under 24 Hrs.	8. Date of Birth	Carro	
	Director		233-38-5050 1 D M 2XXF 8	6 Yrs.		lours Min.	(Month, Day,	Year) 1924 Wes	Birthplace (State or Foreign Country) St Virginia
	nd thow at	٦,	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	ation				10d. Inside City Limits
	/laryla 8a-f s tified	Director		Manche					1 Yes 2XXNo
	the Na or 2		10e. Street and Number	ranere	10f. Zip Code			10g. Citizen of What	Country?
	s filed within 72 hours after death with the Maryland tal Hygiene. 3d ofter than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	5438 Lineboro Road, East		21102			United S of Amer	States ica
· O	or iter	by Fu	11. Marital Status 1 □ Never Married XX Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2√2 No	13. W	as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto l	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
21215-0036	rs afte	ed b	3 Widowed 4 Divorced Year or Dates.	1	☐ Yes ※XXX No Sp	pecify:		Specify: W	nite
<u>က</u>	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupation	n a most of workir	ng.	16b. Kind of Busines	
2	ithin 7 ene. • than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	NOT use retired)	g most of worki	ig .		
2	lled w other rent, t	Be	12th 17. Father's Name (First, Middle, Last)		Homemaker	Mother's Name	(First Middle N	Own I Maiden Surname)	lome
$\overline{\sigma}$	ould be find Mental marked	으	Edward Meridith Presnell			ella (U		raider Surriaine)	
an)	should and Me 7 is mar raumati	10 A	19a. Informant's Name/Relationship (Type, Print)	19b. Mailinç	Address (Street and N			City or Town, State, 2	Zip Code)
``			William S. Miller (Husband)	5438 L	ineboro Ro	ad, Eas	t, Manc	hester, Ma	aryland 21102
Baitimore,	permit. Page 1 and 2 Department of Health Important: If Item 2 any injury or other 1 once.		1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Ma98/	ace of Disposi	ition (Name of atory Baptist Lagran	i D		20c. Location - City of	
	nit. Pa artmer ortani injury	1	4 □ Donation 5 □ Officy (Specify) 21. Signature of Fun (all Springe Licensee	<u>rch Ce</u>	metery	_ : 20		Manchester	, Maryland
n	permi Depar Impo any ir once.		Em amula		Name and Address of				pel, P.A. land 21102
			234. Roll: Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter	the mode of dying, such	ch as cardiac or	respiratory arres	ster, Mary	Approximate
	nysician/	or b	Immediate Cause (Final disease or condition	$\Delta \Lambda$					Interval Between Onset and Death
66	Medical Examiner		resulting in death) a. Due to (or as a consequent of the conseque	nce of):					
		e.	Sequentially list conditions, if dry keating to know date	noo of:					
n.	ansit	amir	cause. Enter Underlying Cause (Disease or iinjury	50115					
p.	execu an an- irial-tra		that initiated events resulting in death) Last				· · ·		
3	cate be executed physician and s the burial-transit	Physician/Medical Examiner	d						
00	ding p	Š	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance						
5	eath certifica attending p	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal of 1 ☐ Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date of do	elivery Day Year
, i	the di by the achec	yy.	g ☐ Unknown						
	gnec oe de	ρ	Part II. Other significant conditions contributing to death but not result	ing in the und	derlying cause given in	Part I.	23e. Did toba	- /	o the cause of death?
2	equire een si nould	eted			- Addition	 -	1 🗌 Ye	s 2 No 3 🗆 1	Probably 4 🗆 Unknown
2	has b	Completed		v			24a. Was an autopsy	y prior to	utopsy findings available completion of cause of
	ician: The la certificate ha ector, page ;		25. Was case referred to medical				perform 1 Yes 2		s 2 🗆 No
	rnysician: this certifica al director, p	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EF	2/Outpotiont	Othori	f Death (Check of	<u>.</u>		
5	ig Fin ter this		27. Manner of Death 28a. Date of injury 28	Bb. Time of injury	28c. Injury at			nce 6 Other (Spe	cify)
	tending leath. I for: Af	Certificate:	2 Accident Investigation		M 1 ☐ Yes	2 🗌 No			
	To the mospinal or Attending Pray, within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral d	Se	4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street	t, factory, office	28	3f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
1	hours neral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Charles Control of the Certifying Physician)	ge, death ocr	cured at the time, date	and place, and	due to the cause	e(s) and manner as st	ated
j	ine no in 24 ine Fu ine Fu	Med	(Check 2 ☐ Medical Examiner: On the basis of examination are only one) 3 ☐ Certifying Nurse Practioner: To the best of my kn	nd/or investia:	ation, in my opinion, dea	ath occurred at th	e time date and	place and due to the	cause(a) and manner stated
ļ.	Z Market	1	29b. Signature and title of certifier		29c. License numb	ber		d. Date signed (Mont	h, Day, Year)
		-	1/8/11			7076		1-11-11	<u></u>
	10	1	30. Name and address of person who completed cause of death (Item 23	Ja) (Type, Prin	7000 /	Mond.	che - F	al M.	of of the
	State	3	31. Date filed (Month, Day, Year) 32. Registrats Signature	N. S.	2000 /	- Tancil	500	1-10,1	211021
	Registra		JAN I & ZUIT Chroma P. Maga	A Comment					2110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00249 State of Maryland / Department of Health and Mental Hygiene James H. Minnix 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ 2322 hrs **Medical Examiner** James Howard Minnix January 8, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore City Univeristy Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Feb. 19, 1960 50 Country)Maryland 219-80-8546 1 X M Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Yes 2 X No Anne Arundel Severna Park , or items 23a or 28a-f show Marylnad Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21146 United States 263 Arundel Beach Rd. Funeral 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 2 X No Yes White Pages 1 and 2 should be filed within 72 hours after of truent of Health and Ment: Hygiene.
 Prant! If item 27 is marked other than "natural", o yor other traumatic event, the Medical Examine. 3 Widowed 4 Divorced Yes, Give Yea Yes 2 X No specify: Specify: <u>۾</u> or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 Construction Flagman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Imogene Shifflett Be Grover Howard Minnix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 263 Arundel Beach Rd., Severna Park, MD 21146 David A. Minnix / Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Itimore, crematory or other place) Januar 1 XBårial 2 Cremation 3 Removal from State 12, 2011 Glen Burnie, Maryland Glen Haven Mem. Park Donation 5 Other Specify ²² Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E.. Glen Burnie 21. Signature of Funeral Service Licensee MD 21061 Crain Hwy., S.E., Glen Burnie, 23a. Part J. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Month 1 Live birth Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 No 1 🗸 Yes 2 No Hospital nr Attending Physician: 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA No 1 Yes 2 28a. Date of Injury (Month Day,Year) Jan 8, 2011 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Pedestrian struck by auto 1 Natural 2222 hrs within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Yes 2 🗸 No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 | Could not be Suicide Certif or Town, State) Ritchie Hwy S/B prior to Robinson Rd., Severna Park, M determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ţ and manner stated

State Registrar

29b. Signature and title of certifie

Pamela E. Southall, MD

noleted cause of death (Item 23a) Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	tate of Maryland		artment of F					
I	Physici		1. Decedent's Name (First, Middle, Last) AND W T	Pinkner		inouto or i		2. Date of De Month		year 9:10a. M	
diam's de	/Medio		4a. Facility Name (If not institution, give stre	et and number)	1	4b. City, Town, or		Death	4c. County of		
	Funeral Director		337-20-6405	ga Street 7. Age (In yrs. Ia X□ F 91	ast birthday) Yrs.	If Under 1 Year Months Days	More If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da	iy, Year)	9. Birthplace (State or Foreign Country)	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State		Town or Lo					10d. Inside City Limits 11 Yes 2 □ No	
	or 283	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?	
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28e-f show event, the Medical Exardine must be modified at	by Funeral	1 ☐ Never Married 2 🔀 Married	Was Decedent Ever in U.S Armed Forces? 1 ☐Yes			1223 dispanic Originan, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)		S.A. e- American Indian, k, White, etc.	
21215-0036	nin 72 hours e. In "natural" Medical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade continuous) Elementary/Secondary (0-12)	Year or Dates: on mpleted) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most o	of working	16b. Kind of Bus		
21	should be filed within and Mental Hygiene. marked other than imatic event, In I.M.		12th grade	na	W	elder	40 14-45-2	Name (Eirot Middle	Westin		
land	e d stal	To Be	17. Father's Name (First, Middle, Last) Rance Saucier					Name (First, Middle, Jones	, warden Surname	<i>e)</i>	
Maryland	2 should be f and Mental Is marked or aumatic eve	-	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailii	ng Address (Street			er, City or Town, :	State, Zip Code) 21223	
	1 and 3 Health Sem 27	1 2	James Pinkney-Hus 20a. Method of Disposition	band 20b. Pl	2230	West Sa esition (Name of matory or other place	arato	ga Street		imsore, Md City or Town, State	
Baltimore,	permit. Pages Department of Important: If it any Injury or o	3	1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. Signature 3 Funeral Service Licensee	oval from State	riso	n Forest	t Vet			gs Mills, Md	
1	Physician	8 1	23a. Pa . Enter the disease, or complication is ock, or heart failure. List only one of the sease or condition	ons that caused the death ause on each line.			ng, such as ca		rrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner	L	resulting in death) Sequentially list conditions b. —	Due to (or as a consequent	ence of):	thine	,				
· ·	cate be executed ohysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	ence of):	a16 % - 0 / 0.01					
8760,	icate be physicia the bur	dical	d								
O. Box 6	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date Mor	e of delivery nth Day Year	
rds, P.	tuires that t n signed by ild be detac	þ	Part II. Other significant conditions contrib	outing to death but not resur	Iting in the u	nderlying cause giv	en in Part I.	23e. Did 1	1/	ibute to the cause of death? 3 Probably 4 Unknown	
Record		Completed	motory of bre	roke	cer			24a. Was auto perfo	psy p ormed? d		
Vita	sician: certific rector,	Be	25. Was case referre to medic I examiner?	pital:		-t all pot Oth	or:	of Death Check only			
n of	ding Phys h, After this funeral di	on: To	1 Yes 2 No Post 1	1 ☐ Inpatient 2 ☐ B 28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Injur	ry at 'k?	i	how injury occurre		
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific: completely filled in by the funeral director,	Certification: To	2 Accident investigation	28e. Place of Injury - At hor building, etc. (Specify]Yes 2 □ N			er or Rural Route Number,	
	Hospita 24 hours Funera stely fille	Medical C		an: To the best of my know On the basis of examinat and magner stated.							
<u> </u>	To the within 2 To the complete	Med	29b. Signature and title of certifier	2000-		29c. Licens	se number	5	29d. Date signed	d (Month, Day, Year)	
•			30. Name and address of person who comp	leted cause of death (Item	23a) (Type,	Print) GO(M.C	andine	STS	1143	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure ba	west of	5/4	- Inch			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 Physician/ Month Year Paige Daniel 35PM 3% JANYAM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Randallstown **Examiner** County of Death Baltimore Season's Hospice Social Security Number 8. Date of Birth 0 3 / 1 7 / 1 9 7 3 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F Hours 024-56-4662 37 Director Yrs. MA Usual Residence of Decedent 28a-f shov nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arthrent of Health and Mental Hygiene. arthrent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Owings Mills Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11214 Park Heights Avenue 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2x No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗎 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unkn. Roberta Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11214 Park Heights Ave., Owings Mills, MD Barbara Henry Friend 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State remetery, crematory or other place)
Final Journey Crem. 1 Burial 2X Cremation 3 Removal from State 1/11/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD CX -Maishal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Renal Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 \(\text{Yes} 4 - Nursing Home 5 - Residence 6 Other (Specify) ent hospice 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 I Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iours after death. Ieral Director: A filled in by the fu 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fil Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier AS Rujapahrel M. 7 29d. Date signed (Month, Day, Year) 1/5/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 NIS. Rajapakse, MID Bultimore, MD 21209. 2835 5 MIM N -5203-

DHMH 17 Rev 7/2009

State Registrar 3. Registrar's Signature

1-00180		Please Type or Print in Black Indelible Ink. Ensure All Copie		ole.	
tacey Ann Pilk	епс	1- For State Certificate of Death	_	2011 00426	
Physici Jedical Exami		1. Decedent's Name (First, Middle, Last) Stacey Ann Pilkerton	Reg. N 2. Date of Death Month Da	3. Time of Death	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air	January 6, 20	4c. County of Death Harford	
Funeral Director		5. Social Security Number 220-82-0506 6. Sex 1X M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		M/DD/YYYY) 9. Birthplace (State or Foreign Country) A	
~		Usual Residence of Decedent 10a. State 10b. County 110c. City. Town or Location			
7423 Maryland r 28a-f show any	tor	MD Harford Edgewood		10d. Inside City Limits 1 Yes 2 No	
th the Mar 23a or 28a notified al	al Director	10e. Street and Number 1428 St. Michaels Ct. 10f. Zip Code 21040		Citizen of What Country? USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumante event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1) 14. Was Decedent Ever in U.S. 15. Armed Forces? 16. Yes 2 No 17. Yes 2 No specify:		14. Race - American Indian, Black, White, etc. White	
ours aft ntural"	d by	Lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	ork done 16b	Specify: . Kind of Business/Industry	
136 thin 72 ho ne. than "na edical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retirementary. 1 2 Medical Secreta	, and the second	Medical	
215-0(be filed wintal Hygier rked other ent, the M	To Be		(First, Middle, Maide anne Ur	•	
MD 21 d 2 should th and Me n 27 is man numatic ev		19a. Informant's Name/Relationship (Type, Print) Richard S. McHenry 19b. Mailing Address (Street and Number or R 1428 St. Michaels (Street and Number or R			
MOFe, Pages 1 an nent of Hea nut: If iter		4 Donation 5 Other Specify:	/2011	c. Location - City or Town, State Woodbine, MD	
Balti permit. Departm Imports injury		21. Signature of Fugeral Service Licensee Dorota Marshall 22. Name and Address of Facility Mary Land Crei PO Box 1413	Raitimo	nre. Min 21203	
Physician III		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease a. Verapamil Intoxication	respiratory arrest, s	hock, or heart Approximate Interval Between Onset and Death	
Examiner		or condition resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
executed in and il - transit	cal Exa	events resulting in death) Last Due to (or as a consequence of): d.			
0 27		▼ UNPENDED □ AMENDED 23a,27,28a-f per me g912 2-9-	F-		
certif certif nding		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		3d. Date of delivery Month Day Year	
ires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?	
- 8 20 a	ompleted		24a. Was an autopsy	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of	
of Vital Records, ag Physician: The law require this certificate has been sineral director, page 2 should t	ပြ	25. Was case referred to medical 26 Place of Death (Check or	performed? 1 Yes 2		
n of Vital I	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	Home 5 Resid		
-5 .< 3	틽	Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 4 Homicide 4 Homicide 5 Pending Investigation 6 Received the suicide 6 Received the suicide 6 Received the suicide 6 Received the suicide 1 Received the suicid			
Division pital or Attendipours after death.	ertifica				
	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
jul	¥	29b. Signature and title of certifier 29c. License number O.C.M.E.		Date signed (Month, Day, Year)	
Ø	İ	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	e, MD 21223		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 DOROTHY PERLBERG JANUARY 10 3:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CASEY HOUSE ROCKVILLE MONTGOMERY 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 💢 F Months Hours Country) Director 292-18-9559 0872371924 86 Yrs OH Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a, State 10b. County ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location Director 10d. Inside City Limits MD MONTGOMERY 1 Yes 2 X No SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14510 HOMECREST ROAD, #2026 20906 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the 12 CLERICAL RETAIL marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Mern Important: If item 27 is marke any injury or other traumatic. NATHAN GOLDBERG EDITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGERY RAPPORT/DAUGHTER 9301 ANGELINA CIRCLE, COLUMBIA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ETERNAL LIGHT MEMORIAL GARDENS 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2011 BOYNTON BEACH, FL 21. Signature of Juneral Service Licen e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SMALL BOWEL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ISCHEMIC CARDIOMYOPATHY 1 Yes 2 No 3 Probably XX Unknown should 24a. Was an 24b. Were autopsy findings available page 2 prior to completion of cause of death? performed? Yes 2 X No 1 ☐ Yes 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 👿 No ည Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier (Check 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Certifie 29d. Date signed (Month, Day, Year) Corcu D37142 1-10-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Piccaro ma Date filed (Month, Day, Year) State 12 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BU M Medical 4a. Facility Name (if not institution **Examiner** 4b. City, Town 4c. County of Death TIMORE **Funeral** If Under 1 ast birthday If Under 24 Hrs. 8 Date of Birth Month Day, Birthplace (Sta Country) or Foreign 1 **⋈** M 2 □ F 3-30-516 Months Days Min. Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County Funeral Director Town or Location 10d. Inside City Limits 1 🗹 Yes 2 🗆 No timore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' Black, White etc Completed by 1 Never Married 2 Married altimore, Maryland 21215-0036 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) e. DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, La 18. Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 1-13-2011 22 Name and Address of 21. Signature of Funeral Service Acensee Vaughn (more 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Bbx 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Day Year signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Meumartius within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The 2 🗌 No Yes 2 No 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tyes 2 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 1 2 2011

JU13-

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NUARO シフロム Medical Examiner Town, or Location of Death County of Death Olen Funeral last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Director Country) MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter once. 10a, State 10c. City, Town or Location Director 10d. Inside City Limits MD Himore Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 o Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life DO NOT use retired) Elementary/Seconday (0-12) Hide Be Father's Name (First, Middle, Last, မ 19b. Mailing Address (Street and MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si y a re of Funera Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day been signed by the should be detached Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No has page 2 s 10 After this certificate 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only on 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🔲 Yes death. Accident Investigation 2 🗌 No 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 01 2011 Physician/ 04:00 рм Reed Eugene Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 6306 Eastern Parkway If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Min Country) Months 10/12/1932 1 X M 2 - F MD 78 Director 216-28-0344 Usual Residence of Deceden 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10a, State Director 1 X Yes 2 ☐ No Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21214 6306 Eastern Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married ģ within 72 hours after 1 Yes 2 X No Specify: י "her than "natural", נ t, the Medical Exam If Yes, Give Year or Dates **Unknown** Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) **HVAC** Technician 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Be 17. Father's Name (First, Middle, Last) Finnerty ၉ Reed Estelle William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6306 Eastern Parkway, Baltimore, MD 21214 Glenda Reed, Wife other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of h Important: If ite any injury or ot Page 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hilltop Svc. Corporation : 01/12/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. permit. 21. Signature of Funeral Service Licensee once. 5305 Harford Road, Baltimore, MD 21214 levandra don 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) Ph. sician/ Medical Due to (or as a consequence Examiner Sequentially list conditions Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) physician Physician/Medical certificate be the as attending properties ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descent at time of death 5 Other (specify) IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Day Year the Hospital or Attending Physician: The law requires that the death in the past 12 months? Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: Natural 2 Accide injury 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director: A completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

DHMH 17 Rev 7/2009

Mills

Lawrence

31. Date filed (Month, Day, Year)

MIS

0

32 Registrar's Signature

Kempritan Hoy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Steve D. Satchell 8 M Medical HNUARY 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAZ BALTIMORE DINAI Social Security Number Funeral 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) er 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 12-3-1956 Year) Days Director 214-68-2737 Months Hours 54 MD Usual Residence of Decedent 10a. State at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f s notified MD Baltimore Gwynn Oak 1 🗆 Yes 2 💢 No 10e. Street and Number ò 10f. Zip Code ıral", or items 23a oı Examiner must be 10g. Citizen of What Country? Funeral 2407 Lawnwood Circle 21207 USA permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces?7 1 Yes 2 ANO If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced SpecifyAfrican-American Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry 12th (0-12) College (1-4 or 5+) Service Tech Sears Be 17. Father's Name (First, Middle, Last) UK 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Peggy Satchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Carolyn Burden/Friend</u> <u>2407 Lawnwood Circle,</u> Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 4 Donation 5 Other (Specify) Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility VII & Funeral Home F.A of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Oncet and Death Physician/ TONTINE MORRHAG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indeet). Examiner Dim to for as a our section or of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy5 Other (specify) Day the the Pregnant at time of death Month Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s After this certificate performed 1 Tyes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Pes 2 No 5 Pending injury Accident 24 hours after deatl filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number D46061 11 d address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Fraure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frank Joseph Sudano Month Vear 1.19 A Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FRANKLin Sauare 20sedale Hospilal BalTimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 Sex **Funeral** 9. Birthplace (State or Foreign 1 XXM 2 □ F Months Days Hours Min. March 30 217-40-2228 1940 Director Marviand Usual Residence of Decedent 28a-f show 10a State with the Maryland Department of the lith and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10h County 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 413 Lyndale Avenue 21206 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, RAN Armed Forces þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 X Divorced White Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Inspector Rail Road Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ည Orazio Sudano Sarah Vintz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
214 Lyndale Avenue Baltimpre Marvland 21236 Sarah Sass/ Niece Baltimore Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Most Holy Redeemer 1/14/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland permit. I 21. Signature of Furneral Service Licer any in once. 22-Nargand jodrikočk, inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annroximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Heute Myocardial infarction
Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): al ending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Yes 2 No Year the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available eral Director: After this certificate has filled in by the funeral director, page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 1 Tyes 2 🔲 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODOO 1-10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR KeusalyA Arunagiri 9000 FRANKLIN Souve DR Balto ind 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decement's Name (First, Middle, Last) 2. Date of Death Month **Physician** toward lyson 2:05 PM Leon DANUARY /Medical 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL AGNES 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1939 9. Birthplace (State or Foreign Country) D. C. **Funeral** 220-36-114 1**M** M 2□ F Months Days Hours Min **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location or 28a-f show notified at show 10d. Inside City Limits MDBaltimore **Funeral Director** 1 MYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ; r must be r Avenue 21229 USA be filed within 72 hours after death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items : any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes 2 No Specify: Blac Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker Father's Name (First, Middle, Last ouis lyson ear 9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Ballimore. onzella 704 md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition -20-2011 Owings Mills, OnD 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Croteene funeral Gervius 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 15CHEMIC 1A45 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Denknown HYPERTE NJ10 24b. Were autopsy findings available prior to completion of cause of death 2

1 ☑ Yes 2 ☐ No 24a. Was an certificate has DIABETE. 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 patient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of co 29c. License number

State Registrar

DHMH 17 Rev 1/2001

900CATON

30. Name and edress of person who completed cause of death (Item 23a) (Type, Print)

COLANDREA, MD
Year 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mary		partment of Health		ygiene	
			Registrar 1. Decedent's Name (First, Middle, Last)	<i>C</i> (ertificate of Death		Reg. No.	10435
	Physic /Medi		CHARLES VENICK	_		2. Date of D Month	Day 🔾 Year	3. Time of Death
	Exami	ner	4a. Facility Name (If not institution, give street and number) Siral Hosoital of Rultimov	- 0	4b. City, Town, or Location	of Death	4c. County of Dear	th
	Funeral	7		yrs. last birthda	Baltimore.	24 Hrs. I & Date of B	N/A	thalon (Ot to the
	Director		214-40-1647 1X M 2 F 6		Months Days Hours	24 Hrs. 8. Date of B (Month, D 03/08/	Pay, Year) Co	thplace (State or Foreign buntry)
	and		Usual Residence of Decedent 10a. State	. City, Town or I	continu	1037067	1344	MD
	Maryll	ţ		**	ALTIMORE			10d. Inside City Limits 1/10/LYYes 2 □ No
	th the or 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	
	ath wil	ral	3601 FORDS LANE, #103		21215		USA	,
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ent, the Madical Examiner must be a cultified at	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 ★ Never Married 2 Married 12. Was Decedent Ever Armed Forces?	n U.S. 13	. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexican	igin? (Specify Yes or No.) n, Puerto Rican, etc.)	0- 14. Race - Ame Black, White	
5-0036	iurs af	b	1 Never Married 2 Married IV S S 2 No IVES, Give Year or Dates:		1 □Yes 2 X No <i>Specify</i> :		Specify: W	HI TE
ر ا	72 hc 'natur	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation	t of working	16b. Kind of Business/	Industry
7	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		e kind of work done during mos DO NOT use retired) ORIVER	t or working	TD ANGRORES	T
ס ס	il Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	1003 [er's Name (First, Middle	TRANSPORTA	110N
ylar	Menta Menta arked atic ev	70 E	MORRIS VENICK			RICE	CHESLER	
	h and h is m		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street and Number			Zip Code)
–	1 and Healt lem 2		CHARLES P. VENICK/COUSIN 20a. Method of Disposition		SMITH AVENUE,	BALT IMOR Date		f
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be a cofficed at once.		1 🔀 Burial 2 □ Cremation 3 □ Removal from State	MIKKO	rnelon prother place)		20c. Location - City or T	
a	permit. Departm Importa any inju		21. Signature of Funeral Service Icens	1H 15RF	AEL CEMETERY 01 2.2. Name and Address of Facility 2.0.000 DELICIES CT	/11/2011 Y SOL JEVIN	BALTIMORE, 1	MD_
٥	90 E # 9		Millian Truger	C	DAOO KETZIEKZIU	IWN ROAD P	IKESVILLE N	D 21208
			23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not er	nter the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
, , ,	Physician /Medical			rdial	Infarctio	N		and Death
	Examiner		Due to (r as a cons		pastric uic	9 (24 hours
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):	The best of the be			24 hours
6	execut n and al-tran	xan	that initiated events resulting in death) Last	sequence of):				
3	ificate be executed g physician and s the burial-transit	edical	d.	- 1				
		Med	IF FEMALE:					
3	Autending Prysician: The law requires that the death cert redail. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	etal death 3[Ectopic pregnancy		23d. Date of deli	,
5	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	or death 5t	Other (specify)		Monar	Day Year
5	es tha gned oe det	by P	Part II. Other significant conditions contributing to death but not	esulting in the u	nderlying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
5	requir	ted	End Stage Reval Disease; Pu		my Hyperten		∕es 2 No 3 Pro	bably 4 Unknown
	has the general page 2 si	Completed	Previous Cardiac Arrest; L		indle Branch	auto	by prior to co	opsy findings available ompletion of cause of
Í	an: IT tificate or, pag		Chronic obstructive Pulmon 25. Was case referred to medical	ary D	isease infected	Cotacath 1 □Yes	rmed? death? 2 No 1 ☐ Yes	3000
	nysrcii iis cer direct	To Be	examiner? 1 Yes 2 No Hospital: 1 20 patient 2	☐ ER/Outpaties	Other	of Death (Check onl o	ne) dence 6 ☐ Other (Spec	
	Ing Pr	iio	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year,	28b. Time o			now injury occurred	ny)
	death ctor: /	cati	2 Accident investigation		M 1 ☐ Yes 2 ☐ N			
1	after safter I Direction by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe	nome, farm, str	eet, factory, office	28f. Location (S City or Tou	Street and Number or Rur vn, State)	al Route Number,
	unera unera		29a. Certifier (Check only (Ch	nowledge, deat	h occurred at the time, date and	place, and due to the	cause(s) and manner as	stated.
the L	To use negotial or stated and prysician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated. 29b. Signature and title of certifier	mation and/or in	vestigation, in my opinion, deat	n occurred at the time,	date and place, and due t	o the cause(s)
ř	₹ 5 8		250. Signature and title of certailer	2000	29c. License number	i i	29d. Date signed (<i>Month</i> ,	
		-	30. Name and address of person who completed cause of death (lit	em 23a) (Tvne		0 4	01/09/12	511
			JAMSHED ZUBERI MD, DETT SU	RUGRY,	SINAI HOSSITAL	BALTIMOVE	= MD 2120	2
	State Registra	_	31. Date filed (Month, Day, Year) JAN 12 2011 JAN 12 2011	nature And	relate			
			COLI CERTON	La. Char				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State	State of Maryla	-			Mental Hy	giene	. a .
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Ce	ertificate of L	Jeatn	2. Date of De	Reg. No.	1,00436
	Physicia Medi		John Francis W	alsh				January	Day Yes	3. Time of Death 6:00 P M
ν.	Exami		4a. Facility Name (if not institution, give			4b. City, Town, or	r Location of Deat		4c. County of D	
100,000	<u> </u>		Gilchrist Hospic			Towson			Baltim	ore
	Funeral Director		063-24-7138	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) ew York
	ind show at	ō	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	//anyla 8a-f s tified	ect	Virginia Loudou	, P,	ırcellv	illo				1 ဩ Yes 2 ☐ No
	a or 2	٥	10e. Street and Number		1100111	10f. Zip Code			10g. Citizen of What	Country?
	h with	Funeral Director	529 Wordsworth Ci	rcle		20132			U.S.A.	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ক্র	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	1 X Yes 2 □ No If Yes, Give 1 0	953 955	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	in, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Black, W	
8	nours latura ical E	Completed	15. Decedent's Ed	Year or Dates.		edent's Usual Occup			W.	hite
215	n 72 ł s. an "n Medi	ם	(Specify only highest gra-	de completed) College (1-4 or 5+)	(Give	kind of work done of NOT use retired)	ation during most of wo	rking	16b. Kind of Busine	ss Industry
2	withi giene ger th		Elomentally/occorday (0-12)	4 4]	Manager			Internatio	onal Marketing
nd	e filed Ital Hy ed ott	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	,	
≌	uld b d Mer mark matic	_	James Walsh		-			nne McKe		
Ma	d 2 should be file alth and Mental I 127 is marked o or traumatic eve	ľ	19a. Informant's Name/Relationship (Ty) Anne M. Walsh (Wi	ife)					; City or Town, State,	
ē,	1 and f Hea item other		20a. Method of Disposition	20b		osition (Name of	n Circle	, Purcel	1ville, VA	
<u>E</u>	Page nent c ant: If any or		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specify	Removal from State		matory or other place itan Crema	· •	/6/2011	Alexandri	
Baltimore, Maryland 21215-0036	permit. Departr Imports any inju	13 	21. Signature of uneral Service Licen		H ₂	2. Name and Addres	s of Facility		, VA 20134	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the de	ath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arm	• VA 20134 est,	Approximate
	Hnysician/	6 N	Immediate Cause (Final disease or condition	e cause on each line.	440					Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conse	quence o):					
		ē	Sequentially list conditions,	o. —						
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iiriju y	Due to (or as a conse	quence ot):					
b	execur in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
09/	icate be executed physician and s the burial-transit	ledical		d						
289	rtificar ing ph e as th	/Me	IF FEMALE:						10.50	
P.O. Box 6	death ce he attend ed for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of o Month	delivery Day Year
9	at the d by t letach		Part II. Other significant conditions cor		esulting in the I	Inderlying cause give	en in Part I	00. Didus		
<u>,</u>	uires the signer of the color o	d by	Sepsis					1 🗆 Y	_	to the cause of death? Probably 4 Unknown
Division of Vital Records,	w requ	plete	1					24a. Was a		autopsy findings available
ec Y	The lar	Completed						autops	sy prior to med? death?	completion of cause of
<u> </u>	ertifica ector,		25. Was case referred to medical examiner?			26. Pla	ce of Death (Chec	1 \(\sum \) Yes :	Z A NOI ILIT	es 2 No
<u> </u>	Physic this or	욘	1 ☐ Yes 2 📈 No H	ospital:			4 □ Nursing H	ome 5 🗆 Reside	ence 6 Other (Spe	ecity) Hospice
0	ding l th. After funer	gate	1 Katural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work?		28d. Describe ho	w injury occurred	
<u> </u>	Atten r deal sctor: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	ome, farm, stre		∕es 2□No	28f Location (St	reet and Number or R	ural Pauta Number
2	tal or rs afte al Dire ed in t		4 - Nomicide determined	building, etc. (Special	(y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town		urar noute Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Crieck /2 L. Intedical Examine	cian: To the best of my knower: On the basis of examination of the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of machine in the best of my known in the	on and/or invest	lastion, in my opinion	death occurred a	t the time date an	d place and due to the	. aauaa/a) and maaaaa
	Voith Com		29b. Signature and title of certifier			29c. License	number		9d. Date signed (Mon	
•	ارا	1	190	W.D.			71287		15/11	
-	り		30. Name and address of person who con	mpleted cause of death (Iter	m 23a) (Type, P	rint)	5 lline	B -IL		A11.011
	State		31. Date filed (Month, Day, Year)	670 N. Cau	ature	St. Suite	<u> 4105 (</u>	DAITU	nove, MD	41704
	Registra		JAN 1 2 2011	To week of	france store	ò				

11-00145	
----------	--

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tony Maurice	Whe	1 .F	- For State Registrar		te of Maryla		partment o e <i>rtificate o</i>			d Mental	Hygiene	Reg. No	20	11 0043
Physi Medical Exa		4	1. Decedent's Name Tony Mauri 4a. Facility Name (if		•						2. Date of D Month January	eath Day 5, 201	Year 1	3. Time of Death 0035 hrs
			Rt. 301 @ E	. Hawthorn		mber)		4b. City, Town, or Location of Death La Plata			ath	4c. County of De		Death
Funer Directo			5. Social Security No. 218–08–7174 Usual Residence of	1	Sex M 2 F	, , , , , , , , , , , , , , , , , , , ,			If Under 1 Year If Under Months Days Hours		Irs. 8. Date of Infin. 05–22		ÌF	9. Birthplace (State or oreign Country)
ith the Maryland	Funeral Director	1	10a. State 10b. County 10c. City, Town or I In Indian Indi					10f. Z	ip Code 20646				izen of What	10d. Inside City Limits 1 Yes 2 No Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. In moditant: If fired 71 is marked other than "satural", or items 23a or 28a-f sho	leted by Funera		Marital Status Never Married Widowed Decedent's Educetors	4 Divorce	ed Armed Fo	rces? 2 No e completed)	If Y	Yes Yes	cify Cuban, 2 No al Occupation	Mexican, Pue specify:	Specify Yes or reto Rican, etc.) of work done etired)		White, e	rican-American
MD 21215-0036 and 2 should be filed within 7 th and Mental Hygiene.	To Be Completed		7. Father's Name (F Cony M. Whee 9a. Informant's Nam	atlev Sr.			Protect:		18	Mother's Nar Fdith	ne (First, Middle Singlet r Rural Route Nu	, Maiden	,	State 7 in Code)
Baltimore, MD osmit. Pages 1 and 2 sho Department of Health and Important: If item 27 is		21	Edith J. Si Ca. Method of Dispo Burial 2 Donation 5 Sunature of Furne	Sition Cremation Other Speci	Removal from	m State	6223 The Place of Disposion of the County of	ition (Na ner place Vete	ameda, ame of ceme e) erans	Baltimor etery, 1-1	<u>re, MD 212</u> Date 4-2011	239 20c. 1 Ciro	Location - City	y or Town, State
Physicial /Medica		2	3a. Part I. Enter the failure. List only	disease, or cor one cause on	M. Ud	V	/ WI	ie Fu	neral l	Home P.A	. of Balt	erromi	County	Approximate Interval Between Onset and Death
	aminer	S if ca	r condition resulting equentially list cond any, leading to imm ause. Enter Underly Diseass or injury that vents resulting in de	itions, ediate ving Cause t initiated ath) Last	Due to (or as a condition of the conditi	consequence	of):							
Box 68760, e death certificate be executed the attending physician and ed for use as the buriat - transit	cian/M	23	FEMALE: b. Was decedent propast 12 months? Yes 2 No			h nt at time of d	2 Feta	al death er (Spe		Ectopic pregr	iancy		. Date of deliv	very Day Year
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Completed by		art II. Other signific		contributing to d	leath but not i	resulting in the ur			en in Part I. Death (Check	1 Ye 24a. Was autop perfo	an osy	No 3 P	
Division of Vital Records, tal or Attending Physician: The law requirer as after death. al Director: After this certificate has been sife to in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	Certification: To Be	1	examiner? 1 Yes 2 Manner of Death Natural Accident	No	28a. Date of (Month, D Jan 5, 201	ay,Year)	ER/Outpatient 28b. Time of Inj 0030 hrs	3 D	28c. Injury a	ner ₄ Nursi at Work? 2 ✓ No	28d Describe Operator of vehicle	how injur motore	cycle that	collided with motor
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		3 4 29:	Homicide	determine	De	nterstate/l					or Town, S Rt. 301 @ E.	itate) Hawtho	rne Drive, L	
To the How within 24 h To the Fun	Medical	one	b. Signature and title	dical Examine	r: On the basis of and manner stat	examination a	and/or investigation	n, in my	opinion, de	umber	at the time, date	and plac	e, and due to	the cause(s) Month, Day, Year)
+1		30.	Name and address Carol Allan, M		completed cause of ant Medical Ex			nore S			D 21223	L	ury 0, 201	,
S Regis	_	31.	Date filed (Month, I		32. Regis	strar's Signatu	ire							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🕕 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death corte Timore Funeral 7. Age (In yrs. last birthday) f Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth 1 □ M 2 🗓 F 9-18-1936 Director 219-32-0274 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f MD Baltimore 1 ☐ Yes 2 🔯 No Gwynn Oak ō 10e. Street and Number 10f. Zip Code 21207 ed other than "natural", or items 23a or event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 1931 Gwynn Oak Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "--- any injury or other than the permitted of the permitte 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No þ 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2X No Specify. Special African-American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th LPN Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Ulysses Nelson Lucille E. Lamax 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Wilkerson/Husband 1931 Gwynn Oak Avenue, Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Woodlawn Cemetery 4 Donation 5 Other (Specify) 1-13-2011 Woodlawn, MD 21. St na tre of Funeral/Service Licen-22. Name and Address of Facility 927 Liberty Road, Randal Lstown, MD 2113 wylie Funeral Home P.A. of Baltimore County And 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2000 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has autopsy performed? Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 2 🗶 No 1
Yes Other: 1 Inpatient 2 K ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) d address of person fied cause of death (Item 23a) (Type, Print) MO am pagra 31. Date filed (Month, Day, Year)

JAN 12 2011 State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Williams Medical Carrie 5:30p.M 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riverview Rehab Health Center Baltimore Essex 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 03 9. Birthplace (State or Foreign Months Days Hours Min. Director Country) Vrs 249-56-8932 b9 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1009 Brantley Ave 21217 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade na Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ William H. Middleton Rosa Aiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27101 <u>Keith Williams-Son</u> 648 Holly Ave, #25, Winston Salem, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) On-Site 01/11/2011 Baltimore, Md 21. Simature of Funeral Service Lis insee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part Interval Between Immediate Cause (Final disease of condition resulting in death) Physician/ Onset and Death Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated excepts.) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical traemio Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Dav Year the a Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has by page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Yes 2 No Other: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work?
1 ☐ Yes 2 ☐ No Accident after death Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0005517 11/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sebastran 10 July 3023 Earlern 21224 31. Date filed (Month, State egistrar's Signature 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 1.394 M 2011 amp (10 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1 ▼ M 2 □ F Months 90 Jan.11,1920 Director 237-20-8194 N.C Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show her must be notified at X☐ Yes 2☐ No MD Baltimore City Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21205 1400 E. Madison St. Apt. 701 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Examiner 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 ō Specify: Black 1 ☐ Yes 2 🔀 No 2 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Garden & Painting other than Handyman 9th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Williams Cora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James D. Burt (stepson) 3 Park Drive, Gwynn Oak, Md. 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a, Method of Disposition cemetery, crematory or other place) 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) rinity Cem. Jan. 18, 2011 Baltimore, Md. 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home mature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smediate Cause (Final) Interval Between Immediate Cause (Final Electrical Activity **Physician** Pulseless disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cardio my opath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ician and burial-transit Due to (or as a consequence of) Box 68760. iding physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe Yes 2 this certificate has filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 1 Minpatient 2 No 2 ER/Outpatient 3 DOA 1 Yes ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury accurred Certification: re Hospital or Attending P n 24 hours after death.
re Funeral Director: After t 1 X Natural 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January, 10, 2011 NKER M.D 255-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Sud.p Saha M. D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	iryland / I		artment of I tificate of I		nd Mental Hy	0	-	1
	Physici	an/	1. Decedent's Name (First, Middle, Las	_	1 []			Joann	2. Date of De		Ga (7)	3. Time of Death
pilone	Med Exami	cal	Made like 4a. Facility Name (if not institution, give		Webb	7	4b. City, Town, o		Jan	0	4 2011	1602 M
) LAGIIII	iiCi	Howard County				Colum		Death	4	tc. County of Dea Howar	
	Funera Director		5. Social Security Number 6. Sec. 212-20-5528	□ + 4 o [\$7] =	(In yrs. last birt 83	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bin F (Month, B)	rth ay, Year	27 Ma	rthplace (State or Foreign
	land show dat	ţ	10a. State 10b. County		10c. City, Towr	n or Loc	cation					10d. Inside City Limits
	e Mary r 28a-1 notifie	 Jirec	Md. 10e. Street and Number		Balt	imo	ore Cit	у				1x Yes 2 □ No
	with th	Funeral Director	809 South Poto:	mac Stree	et		10f. Zip Code 21224			10g. (Citizen of What C	•
980	e filed within 72 hours after death with the Maryland Ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates,			Vas Decedent of H Yes, specify Cuba		? (Specify Yes or No- cuerto Rican, etc.)		14. Race - Ame Black, Whit	
15-0	'2 hour "natu edical	plet	15. Decedent's Ed (Specify only highest grad	ucation	16a.	Deced	ent's Usual Occup ind of work done o	ation	f working	16b.	Kind of Business	
212	ed within 7 Hygiene. other than ent, the M		Elementary/Seconday (0-12)	College (1-4 or 5+)		life. DC	nbly Li			Cr	own, C	ork & Seal
pu	filed tall Hyged of the sevent,	To Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,	Maider	n Surname)	orn a boar
ıryla	should be file and Mental is marked of raumatic eve		Phillip Jordan 19a. Informant's Name/Relationship (Type)	o Print AllQ	erl				line Pal			
, Ma	1 and 2 should be of Health and Men item 27 is marke other traumatic		Gail M. Laszcz	ynski	49	7 5	Thresh	field	r Rural Route Numbe Court E	111	or Town, State, Zi COLL C	ity, Md2104
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 → Burial 2 → Cremation 3 → 4 → Donation 5 → Other (Specify)	Removal from State	cemeter	y, crem	ition (Name of atory or other plac of Fai		an@æry 3, 2011		Location - City or	Town, State ,Maryland
Ball	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Cicense	е			Name and Addres	ss of Facility &	aczorows	ki	Funera	1 Home, PA
60 Aug	Ph sician/		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final disease or condition	ications that caused the cause on each line.	ne death. Do no	ot enter	201 Dung the mode of dying covoliting	g, such as car	Avenue B. diac or respiratory an	a <u>lt</u> rest,	imore,	Md. 21222 Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a c	onsequence o	f):						
	7 t	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence o	f):						-
	icate be executed in physician and is the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a co	onsequence of	f):				_		
3760	te be e nysiciar ne buria	edical	L.	d								
987	ertificat ding ph		IF FEMALE:	20 If you guttoome of								
Division of Vital Records, P.O. Box 68	In the Hospital or Attending Physician: The law requires that the death certific thin 24 hourst after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of a line of the second	Fetal death		Ectopic pregnancy Other (specify)	<i>y</i>			23d. Date of del Month	livery Day Year
, P.O	ss that 1 igned b be deta	by P	Part II. Other significant conditions con					en in Part I.	23e. Did to	bacco	use contribute to	the cause of death?
rds	require been s	Completed by	- complete heart		- 60	तर	remia					robably 4 🗌 Unknown
Seco	he law te has age 2 s	ошр	- severe septic s	holl					— 24a. Was a — autop perfor	sy med?	prior to death?	topsy findings available completion of cause of
ta .	cian: T ertifica ector, p		25. Was case referred to medical examiner?				26. Pla	ce of Death (C	1 \(\sum \) Yes Check only one)	2 L4 N	o 1 ∐ Yes	2 1 No
<u> </u>	Physi rthis c ral dire	2	1 ☐ Yes 2 ☐ No ☐ ☐ 1 ☐ Yes 2 ☐ No ☐ ☐ 1 ☐ Yes 2 ☐ No ☐ ☐ 1 ☐ Yes 2 ☐ No ☐ ☐ 1 ☐ Yes 2 ☐ No ☐ ☐ 1 ☐ Yes 2 ☐ No ☐ ☐ 1 ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No ☐ Yes 2 ☐	28a. Date of injury	2 ER/Out			4 L Nursin	g Home 5 Resid			f(y)
on '	Attending Physer death. ector: After this by the funeral di	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye		ury	28c. Injury work? M 1 🗆 1		28d. Describe ho	ow injur	y occurred	
DIVISI	ital or Atte ins after de ral Directo lled in by th	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	Specify)				City or Town	n, State,)	al Route Number,
:	thin 24 hor the Funer mpleted fil	Med	only one) 3 - Certifying Nurse	er: On the basis of exam	nnation and/or	investia	ation, in my opinior	i, death occurr time, date and	and at the time date or	nd place	and due to the o	augustal and mann t- t d
	7 w 7 00		29b. Signature and title of certifier	A.			29c. License	number	- 2	29d. Da	te signed (Month)	
6			30. Name and address of person who cor Dr. Nishi Rawat	npleted cause of death , M.D. 10	7 10 C	pe, Prir har	ter Dri	ive,St	e310,Col	Lum	bia, Mo	1.21044
	Stat Registra	-		32. Regiotrar's							<u> </u>	
DUM	H 17 Rev 7/20		OWN THE	VIII There	n p.	19	aver					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARYANN **Physician** Month Voar BOWLEY 1:15 P M OI 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 300 Sunflower Drive Apt.348 Bel Air Harford If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov 7, 1945 9. Birthplace (State or Foreign **Funeral** 1 □ M 💥 F New Jersev 237-36-3400 65 Yrs. **Director** Nov Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a corrections injury or other traumatic event, the Martin 1 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive Apt. 348 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: White ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Supervisor Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Druezella Miller Stanley L. Buscher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Morrow, Daughter 15 Dallam Apt.#8 Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/12/11 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hage Jan Small disease or condition resulting in death) months /Medical Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should **1**□ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed 2 **X**No 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only on-) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Pescribe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death. the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Ś 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely fi Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Suite

32. Registrar's Signature

egsallamn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

·SIUASALLAN

200

DA5530

111 11

5. Atcoood, Belair 21014

PoberT F. Buss

11-00203 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 | |

		1- For State Registrar		Ce	ertificate	e of De	eath				Reg. No.			
Physic		Decedent's Name (First, Mid-								Date of De Month		Year		3. Time of Death
Medical Exam	ine			-					J	anuary	7, 2011	rear		1026 hrs
		4a. Facility Name (if not instituti		imber)			-	or Location of	Death			County of		
		2260 Cromwell Bridg	e Road			Lo	och Rave	en				ıltimore		•
Funera		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda		Under 1 Ye					D/YYYY)	9. Birt	hplace (State or
Directo		264-61-7294	1X M 2 F	3	6	Yrs.	lonths Da	ys Hours	Min.	Feb.	3,19	74	Cou	Florida
	1	Usual Residence of Decedent												
any	1	10a. State 10b. County		10c. Cit	y, Town or I	Location								10d. Inside City Limits
nd Show		MD Balt	timore		Mid	dle	Rive	r						1 Yes 2 XNo
te Maryland or 28a-f show any fied at once.	1 5	10e. Street and Number				10f	Zip Code				10g. Citize	n of Wha	t Coun	trv?
he M	Director	9779 Bird	River Ro	oad			21	220			US			
with th s 23a e notil	<u></u>	11. Marital Status	12 Was Dec	edent Ever in U	IS 13	3 Was Dec		ispanic Origin	2 / Specif	Von or N			A i	can Indian, Black,
eath v	Funeral	1 Never Married 2 XN	farried Armed Fo	orces?		If Yes, s	pecify Cuba	n, Mexican, P	uerto Rica	an, etc.)	o- '`	White,		an indian, black,
ter d ", or cr m	臣	3 Widowed 4 Di	1 Yes	2 🔀 No		1 Yes	2 🛂 N	o specify:				pecify:	Wh i	te
urs at tural	호	15. Decedent's Education (Spe	or Dates:		16a. Dec			ation (Give kin	d of work	done		d of Busi		
72 ho	Completed	Elementary/Secondary (0-12)						e. DO NOT us			1,00.10	o Daoi	11000	iddotty
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	直	12th			Dr	iver					T	'ow	Tru	ck
S-O ed wi tygies of the	ုင္ပဲ	17. Father's Name (First, Middle	, Last)					18.Mother's N	Name (Fir	st, Middle,	Maiden Su	urname)		
21. Pe fill red F	Be	Robert E.	Buss					Shai	ron	Krep	ps	,		
Duld Mer	ို	19a. Informant's Name/Relations	ship (Type, Print)		19b. M	lailing Add	ress (Stre	et and Numbe				or Town,	State,	Zip Code)
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene, 127 is marked other than "natural", or items 23a or 28a-f sho umstic event, the Medical Examiner must be notified at once.	Ľ	Stacy N. Bu	uss /wife	9	9.	779	Bird	River	r Ro	ad B	alto	. M	D 2	1220
Fe, I and Heal Heal		20a. Method of Disposition		20b.	Place of Di	isposition (Name of ce		Da					own, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 7: is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation	_	m State B	crematory of	orotherpia	^{ace)} remai	tory 1	1/13	/11	Ba	lti	mor	e MD
ii. Partme		4 Donation 5 Other S 21. Signature Fune e i	oecify:	- 4				s of Facility					_	
Dep Depri	10	W. O	120	6 h	/			-	300	Mac	e Av	e. i	Bal	to. MD
Physician		23a. Part I. Enter the discase,	mplications that	ed the death	n. Do not en	nter the mo	onne. de of dying	such as card	iner	a L H	OME rest. shock	OT or head	Ess	ex 21221 Approximate Interval
/Medical		failure. List only one caus	on each line.								,		- 1	Between Onset and Death
≛xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Contact Gu Due to (or as a			пеац							-	
		Sequentially list conditions,	b.		,-									
	ner	if any, leading to immediate	Due to (or as a	consequence o	of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C.											
ted I Insit		events resulting in death) Last	Due to (or as a d.	consequence o	or):								1	
3760, ficate be executed g physician and the burial - transi	/Medical	UNPENDED	AMENDED							_			-	
3760, ficate be g physicials the buris	edi													
	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o	utcome of preg		Fetal dea	ath 3	Ectopic pre	ean ancy			oate of de onth	-	Vaar
X 6 h cert tendir use a	icia	past 12 months?		nt at time of de	eath 5	Other (S			egriancy		IVIC	JIIIII	Da	y Year
Box 687 ne death certific the attending	Physiciar		9 Unknow		ليبا									
P.O. s that the		Part II. Other significant condit	ons contributing to	death but not re	esulting in t	the underly	ring cause (given in Part I.		23e. Did to	bacco use	contribu	te to th	e cause of death?
cords, P.C. law requires that has been signed l	d by								_	1 Yes	2 🗸 N	o 3	Proba	bly 4 Unknown
requ been hould	Completed								1	24a. Was		24b. We	re auto	psy findings available
e law e has ge 2 sl	튑				·				-		rmed?	dea dea		npletion of cause of
Vital Rec ysician: The his certificate director, page	ပိ	25. Was case referred to medical							1	✓ Yes	2 No	1 🗸	Yes	2 No
ician ician s cert recto	å	examiner?	Hospital:		FRIO. 1			of Death (Che						
FV; Physic er this rral dir	۴	1 Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpat 28b. Time		DOA				Residence		Other: S	Scene ———————————————————————————————————
n of \ iding Ph; h. After tl	cation:	1 Natural 5 Pend	(Month L	Day,Year)	1008 hrs			ry at Work? Yes 2 ✔ No	ISub	ject sho	now injury o t self	occurred		
Attend Attend r death rector: by the	Cat	2 Accident Inves	tigation	.61-2							_			
Division of Vital Records, piral or Attending Physician: The law require ours after death. neral Director: After this certificate has been similed in by the funeral director, page 2 should b.	Certific	deter	Thor be	of Injury - At ho		street, facto	ory, office b	uilding, etc.		or Town, S	tate)			Route Number, City
ospit.		20n Cortifion	(0,000)	Parking Lo							rm Road,			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only	ysician: To the best niner:On the basis of	of my knowledg examination ar	ge, death oo nd/or invest	ccurred at	the time, da	ate and place,	and due t	o the caus	e(s) and m	anner as	stated	221160(6)
To T	Med .	29b. Signature and title of certifie	and manner sta	ted.					ou at the	e, uate i				
		A M		. 0		1	29c. Licens							, Day, Year)
		Tamule & Va	theelle No	0			O.C.I	vi.⊏.			Januar	y 8, 20	711	
		30. Name and add ess of cerson		•	,	20034	D = 02	01 -	112					
	أحي	Pamela E. Southall, M						Street, Ba	altimore	e, MD 21	1223			
	ate trar	31. Date filed (Month, Day, Year)	0011 6	istrar's Signatu	T And	are	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené U For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** - Ua 20 i ene /Medical 4c. County of Death 4a. Facility Name (If no institution, give street and number, 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall VA Home Charlotte Hall If Under 1 Year It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2 F Yrs. 244-20-1074 North Carolina 85 01-14-1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State **Mode** the Medical Examiner must be notified at 1 Yes 2000 Directo Columbia Howard 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 end 2 should be tiled within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "" eny hijury or other traummat. 5 U.S.A. 21044 6305 Angel Rose Court items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X☐XYes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2☐xNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Parts District Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lydia Gray Jackson Howard Bowen ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6305 Angel Rose Court Columbia, MD 21044 Cynthia Huesman (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1-14-2011 Glen Burnie, MD 21. Signatural Funerat Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused shock, or heapt failure. List only one cause on each the he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires thet the death certificate be executed use as the burial-transit that initiated events resulting in death) Last P.O. Box 68760 Due to (or as a consequence of) Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital 1 ☐ Yes : After this certifice a tuneral director, 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturat 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation by the 1 within 24 hours efter death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tilled in 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie wil mpleted cause of death (ttem 23a) (Type, Print) 30. Name and address of person who c MD Waldort 20600 7 Kab Old 12070 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

parko

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene per dr., g911,01/13/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 150 14 PM Medical WHAIN 6 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Jersity Security Number 7. Age (In yrs. 78 **Funeral** 8. Date of Birth 9. Birthplace State Foreian 1 🗆 M 2 🔀 F Months Hours 219.28.3311 Country) Director Yrs Usual Residence of Decedent or 28a-f shov "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1timore 1 ✓ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🏲 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify Iack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life_QO NOT use retired) | Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle ည 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 201 . Signature of Funeral Service Licens 22. Name and Address of Facility Vaugnn C Greene Funeral 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21229 atrona Approximate Interval Between Immediate Cause (Final Fuysician, Onset and Denth Universer disease or condition communication CLINELLY Medical resulting in death) Due to (or as a consequence of) ruptore Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day signed by the a detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of cate has the page 2 s 24a. Was an autopsy performed? Yes 2 No his certificate h death? 1 Yes 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Hospital 은 1 Tes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

Ineral Director: After this of filled in by the funeral director. 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation М 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical within 24 hor To the Fune completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 MD 05 1310055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 ho

DHMH 17 Rev 7/2009

State

Registrar

MD

2011

2. Registrar's Signature

MD21201

1- For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

0	00446	
	3. Time of Death	1
Year	1709 hrs	
nty of Death		1
/A		
YYY) 9. Bir	thplace (State or	1
Foreig Co	untry Maryland	
74	Maryland	
	10d. Inside City Limits	
	1XX Yes 2 No	
What Cour	ntrv?	ł
	•	
Α.	can Indian, Black,	
ace - Ameri hite, etc.	сап Іпфіап, віаск,	
_{fy:} Whit	e	
Business/I		
n i + a 1		
pital		
,		
Moras own, State,	Zin Code)	
D 21 on - City or	Town, State	
timor	e MD	
	21224	
heart	Approximate Interval Between Onset and	
	Death	
_		
of delta in		
of delivery Da	y Year	
	,	
ntribute to th	ne cause of death?	
3 Proba	bly 4 🗸 Unknown	
. Were auto	psy findings available	
prior to co death?	mpletion of cause of	
1 🗸 Yes	2 No	

		1- For State Registrar		ertificate of	Death		R	eg. No.		
Physic edical Exam		Decedent's Name (First, Middle	Last)				Date of Dea Month		3. Time of Death	
edical Exam	iner	Karen 4a. Facility Name (if not institution,	Ann		Berge		January 4	, 2011	1709 hrs	
		403 Folcroft Street	give street and number)	ľ	Baltimore	or Location of D	eath	4c. County of D	eath	
Funeral		Social Security Number	S. Sex 7. Age (In yrs.	last birthday)	If Under 1 Ye		4Hrs 8 Date of Rig	rth(MM/DD/YYYY) 9.	Ridhplace (State or	
Director		216-78-3897		,,		ays Hours	Min.	Fo	reign	
		Usual Residence of Decedent	1 M 2 X F 46	Yrs			Nov.	4, 1964	Country Maryland	
/ any		10a. State 10b. County	10c. City	, Town or Locati	on			·	10d. Inside City Limits	
Maryland 28a-f shuw dat once.	5	Maryland N/A		Balt	imore				1XX Yes 2 ☐ No	
Maryl 28a-1	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	ountry?	
ith the d 23a nr notifies		403 Folcroft	Street		21224			U.S.A.		
c death with the Maryland or items 23s nr 28s-f shu must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Ever in U		Decedent of H	lispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. Race - Ar White, etc	nerican Indian, Black,	
er dea	Ξ		1 Yes 2XX No		_		ionio miodri, oto.)	Specify: Wh		
2 hours after "natural", Examiner	by	15. Decedent's Education (Specif	ced If Yes, Give Yeer or Dates:		Yes 2 X N	o specify: eation (Give kind	of work done	Specify: 16b. Kind of Busine		
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working li	fe. DO NOT use	retired)	TOD. KING OF BUSINE	ss/ilidustry	
5-0036 iled within 7 Hygiene. Inther than	ldm		5+	Reg	istered	Nurse		Hospit	a 1	
5-0 iled w Hygic Inthe	ပိ	17. Father's Name (First, Middle, La	ast)				ame (First, Middle, M	faiden Surname)	41	
2121; buld be fil Mental I marked c event,	Be (Stanley	P. Wyso			Caro	lyn	Mor	aski	
MD 2 d 2 shoul lith and M n 27 is m	Ťo	19a. Informant's Name/Relationship						ber, City or Town, St		
Ore, MD 21215-0036 ses 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", ther traumatic event, the Medical Examiner.		Stanley Wysock 20a. Method of Disposition		Place of Disposit		Street	Baltim Date	ore MD 20c. Location - City	21224	
- 90 2 5 5		1 Burial 2 Cremation	3 Removal from State	crematory or oth	er place)					
Baltin bermit. Pa Departmen mponrtan njury or		4 Donation 5 Other Spec 21. Signature of Funeral Service Lic		y Rosar			1/08/2011	Baltim	ore MD	
Balt permit Depart Impur injury	- H	Statoge -		1	Charle	s S. Ze	iler & So	n, Inc. altimore	MD 21224	
Physician		23 P.H. Enter the diseast, or co	mplications that caused the death	. Do not enter the	mode of dying	g, such as cardia	ac or respiratory arre	est, shock, or heart	Approximate Interval	
/Medical Examiner		Immediate Cause (Final disease	a. Complications	of Liv	er Dise	ase			Between Onset and Death	
		or condition resulting in death)	Due to (or as a consequence o	f):						
	힐	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence o	f):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c							
nted d ansit		events resulting in death) Last	Due to (or as a consequence of	т):						
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	X UNPENDED AMENDED 23a,27 per me g911 1-24-11 vt 23c. If yes, outcome of pregnancy 23d. Date of delivery									
760, icate be physici the buri	Me	IF FEMALE:	23c. If yes, outcome of pregi	nancy				23d. Date of deliv	erv	
Box 68		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	oth	I death 3	Ectopic pre	gnancy	Month	Day Year	
30X death e atter	Physiciar	1 Yes 2 No 9 V Unkno		atn 5 Othe	r (Specify)					
O. It the		Part II. Other significant condition	s contributing to death but not re	esulting in the un	derlying cause	given in Part I.	23e. Did tot	pacco use contribute	to the cause of death?	
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	d b						1 Yes	2 No 3 Pr	obably 4 🗹 Unknown	
rds requi	i e						24a. Was a		autopsy findings available	
eco he law ate has	Completed						autops perforr 1 Yes 2	ned? death?		
Vital Rec ysician: The I his certificate I director, page		25. Was case referred to medical	<u> </u>		26.Place	e of Death (Che		No 1	Yes 2 No	
of Vital Records, ng Physician: The law require this certificate has been si meral director, page 2 should b	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient		Othor -		Residence 6 🗸 Oth	er: Scene	
After I	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inju	ıry 28c. İnju	ıry at Work?	28d. Describe ho	ow injury occurred		
Sion Attend r death. ector: by the f	igi gi	1 X Natural 5 Pending 2 Accident Investiga			1 1	Yes 2 No				
Division tall or Attendir rs after death.	Certificati	3 Suicide 6 Could no	and the second s	me, farm, street,	factory, office t	ouilding, etc.	28f. Location (St or Town, Sta		Rural Route Number, City	
ospita hours incral		4 Homicide determine 29a. Certifier	1,5,555)							
Divi	G	(Check only Certifying Physic	ician: To the best of my knowledger:On the basis of examination are	e, death occurre nd/or investigation	d at the time, da n, in my opinion	ate and place, a n, death occurre	ind due to the cause d at the time, date a	(s) and manner as stand due to	ated. the cause(s)	
To with	ĕ⊦	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (M		
		110. B.	· · · · · · · · · · · · · · · · · · ·		O.C.	M.E.		January 5, 201		
		30. Namo and address of person who	completed cause of death (Item	23a)				, 2, -3,		
*			Assistant Medical Examin		Baltimore S	treet, Baltin	nore, MD 21223	3	1	
Sta	ate	31. Date filed (Month, Day Year)	32. Registrar's Signatur	Charles !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ o 1^{Month} 06 Day 2011 Percy Russell Brent Jr. 0:08AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2121 Windsor Garden LA. N/A APt524c Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Days Hours Min. WashingtonDC Director unk 0872271947 63 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD N/A 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Windsor Garden LA.APt524c 21215 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 72 hours after ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black "natural" 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Stewart Home Care (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unk Certified Nursing Assist /assisted living Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Percy R. Brent Sr. Shirley Hickman 19a. Informant's Name/Relationship (Type, Print) (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. <u>Carole</u> E. Jefferys-El 407 Rollins Ave., Capital Heights,MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/13/11 Baltimore, MD 21. Signature of Favoral Service Licens Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onget and Death Physician/ PROGRESSION of Chrowic reval Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner hypertension Severe 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician a page 2 should be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Human Immunudefictury Virus In Fection 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown obesity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate hyserlipidenia 1 ☐ Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Hospital: 1 Yes 2 □ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number D 00 36954 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juite 405 WAYNE N. CAMPSELL 201 E. LINIOUSITY BALTIMORE. DKLAG ma MO 21218 31. Date filed (Month, 14), Page 3 2011 32. Pagistrar's Signature State allers . Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mor Cer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1310 Rosewick√Avenue Rosedale Baltimore Social Security Number **Funeral** 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 21 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min. 235-56-5760 Director 73 937 WVA Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Eventer. 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits Baltimore Rosedale 1 Yes 2 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1310 Rosewick Avenue 21237 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. Armed Forces Black, White, etc. 1 \square Never Married 2 \square Married ģ Yes 2 No Baltimore, Maryland 21215-0036 **¾**□ Widowed 4 □ Divorced If Yes, Give 1 Yes 2 No Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James H. Whited Sarah Bell Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Tucker 8415 Berkfield Road Road Balto. MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Gardens of Faith 1/13/11 Rossville MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Balto. MD Essex 21221 23a. Part 1. Enter the disease, or com ations that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition resulting in death) cum Medical or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exam Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မြ 1 🗌 Yes Other: 4 Nursing Home Residence 6 Other (Specify, After this 1 Inpatient 2 ER/Outpatient 3 DOA Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 No Investigation 24 hours after deat Funeral Director. Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifie 30. Name and address of p ath (Item 23a) (Type, Print) State 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00449 State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20ÏI Jamonth Carroll Topley Croson, Jr. 3:55A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 09/109/14941 231-52-5443 69 Washington, DC Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Funeral Director 1 ☐ Yes 2 🛣 No Maryland Howard Columbia 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 10440 Swift Stream Place Apt 202 U.S.A. 21044 14. Race - American Indian 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notraumatic event, the Medical Examiner Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ni any injury or other traumatic event." (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Business Entrepreneur Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carroll Topley Croson, Sr. Ruth Blue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10440 Swift Stream Place #202 Sandra M. Croson Columbia, MD 21044 (Wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State Atlantic Crematory 1-9-2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the dis. se, or comp collons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Metastalic Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dialula Melilias Type II autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) How 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မူ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending s after death.

I Director: After din by the fur 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) thin 24 hours after de the Funeral Directo impleted filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) Oi MD 08 2011 D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI KUMAR .6701 N BALTIMORIZ CHARLES MD 21204

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of De	ath	Re	g. No.							
Physici Medical Exam		1. Decedent's Name (First, Middle, Last) James Lee Conyers, Jr. JOHN CONYERS JR.		2. Date of Deat Month January 1,	Day Year	3. Time of Death 0345 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. Ci	ty, Town, or Location of I		4c. County of Death							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Under 1 Year If Under 2	24Hrs. 8. Date of Birt	h(MM/DD/YYYY) 9. Bir	hplace (State or nMARYLAND						
Director		215-70-4845 1XXM 2 F 52 Yrs. Moltres Days Hours Mill. 02/27/1958 Country)										
w any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 XX Yes 2 No						
Maryland 28a-f shnw d at once.	Director	MARYLAND N/A BALTIMO 10e. Street and Number 10f.	RE Zip Code	10	g. Citizen of What Cour							
ith the M 23a or 2 notified		5038 QUEENSBERRY AVENUE 11. Marital Status 12. Was Decedent Ever in U.S.	21215	2 / 0 1 / N -	U.S.A.	an Indian Plank						
death wi or items must be	Funeral		edent of Hispanic Origin ecify Cuban, Mexican, P		White, etc.							
ırs after t ural", o	by	or Dates:	2 X No specify: ual Occupation (Give kin	d of work done	Specify: BLA0							
36 n 72 hot nan "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	working life. DO NOT us	e retired)								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Departmet of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f shu injury nr other traumatic event, the Medical Examiner must be notified at once.		12th grade LABOR 17. Father's Name (First, Middle, Last)		Name (First, Middle, M	CONSTRUCT	LION						
2121 uld be fi Mental I marked	o Be	JAMES L. CONYERS SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr	LUC ess (Street and Number	ILLE WITHE		Zip Code)						
MD nd 2 sho alth and m 27 is	_	Barbara Brown/Sister 2320 Br 20a. Method of Disposition 20b. Place of Disposition (yant Ave.,	Baltimore,	Md., 21217							
nore, ages la nt of Hea nt. If ite		1 XXBurial 2 Cremation 3 Removal from State crematory or other pla	ace)	01-07-11	BALTIMORE							
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other to		21. Signature of Fundral Service Licenses WT.L.T.	and Address of Facility AM C BROWN									
Physician	_	23a. Part K-Enter the disease, or complications that caused the death. Do not enter the more	W NORTH AVE: de of dying, such as card	NUE iac or respiratory arre	st, shock, or heart	Approximate Interval						
/Medical Examiner		failure. List only one cause on each line. Smoke Inhalation Co Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	mplicating	Alcohol an	d Methadon	Between Onset and Death						
		Sequentially list conditions, b										
0	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last										
and transit	al Ex	events resulting in death) Last Due to (or as a consequence or): d. 73a 77 78a t por me g9 11 1-20-11 ytt										
760, cate be executed physician and the burial - transit	Medical		X AMENDED 23a, 27, 28a-t per me g911 1-20-11 vt 1perME, G911, 1/13/11, WS 23c. If yes, outcome of pregnancy 23d. Date of delivery									
certifica certifica ending pl	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S		egnancy		ay Year						
Division of Vital Records, P.O. Box 687 ral or Attending Physician: The law requires that the death certific its after death. *al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underly		23e Did tob	acco use contribute to t	he cause of death?						
P.O. res that I signed be detac		Company & death but not resulting in the directly			2 No 3 Prob							
cords aw requi has been 2 should	Completed by			24a. Was ar autops perform	y prior to co	opsy findings available ompletion of cause of						
II Rec	Con	25. Was case referred to medical	26.Place of Death (Ch	1 ✓ Yes 2	No 1 ✓ Ye	2 No						
n of Vital Records, P.C. Jing Physician: The law requires that After this certificate has been signed funeral director, page 2 should be dear	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	DDA Other N 28c. Injury at Work?		Residence 6 Other:	Scene						
ion o tending eath. ior: Aft	ation:	1 Natural 5 Pending (Month, Day, Year) 2 X Accident Investigation 1-1-11 3:18am	1 Yes 2 X No		of house f	ire						
Division In or Attenors after death al Directors led in by the	Certification:	3 Suicide 6 Could not be determined (Specify) residence	ory, office building, etc.	28f. Location (St	reet and Number or Rur							
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate that so the recent of the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at		and due to the cause	(s) and manner as state							
To th within To th comp	Medical	and manner stated.	29c. License number		29d. Date signed (Mon							
100		4M.C	O.C.M.E.	1	January 1, 2011	<u> </u>						
bend		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltim	nore Street, Baltim	ore, MD 21223								
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Karleen Carter Medical January 8 2011 12:16 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 X B Months Hours 215-46-1219 Washington, DC Director 64 November 10, 1946 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits the Medical Examiner must be notified or 28a-f Maryland Worcester Berlin 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 169 Seafarer Lane 21811 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. and Mental Hygiene. δ 1 Never Married 2 Married Yes 2 X No If Yes, Give 1 ☐ Yes 2 🖾 No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Department Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Assistant of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Blasewitz Nancy Lee Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Page 1 and 2 sh
Der artment of Health ar
Important: If item 27 is
any injury or other trau Debra L. Winegar / Niece 1239 Rossback Road, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/12/2011 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 ase 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month ☐ Pregna... ☐ Unknown Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2**X** No 1 Tyes Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ Other: Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 Accident
3 Suicide Investigation 2 🗆 No Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 0064/20 Name and address of person who completed cause of death (Item 23a) (Type, Print) Zeeshon Hogelth Way Drive 33 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 730 PM Aretta Coulter Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOVE cial Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🕶 F Months Days Hours Min. Director 129-24-3354 110/1927 Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he motified — 10a State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 X Yes 2 □ No MD *Harkoro* 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Ewing Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced If Yes, Give White Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Charles Robert Haley <u>Annie Virgie Vires</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Coulter (Son) 216 Ewing Street. Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 A Cremation 3 D Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 01/05/2010 | West Chester, PA A. Ferris & Co.. Inc Signature of Funeral Service Licenses 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 Washington Street, Havre de Grace, ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or each line. 23a, Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 1 Yes 2 Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes e Hospital or Attending Physician: 1 124 hours after death. e Funeral Director: After this certifics leted filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 2 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work' 1 Yes 2 🗆 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the bear of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one Certifying Nurse Practioner: To th best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the title of certit 29b. Signature 58 30. Name and address of person o completed cause of death (Item 23a) (Type, Prigit FREILICH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cathleen Caponiti	1- For State Registrar	ate of Maryland / Depa <i>Cer</i>	artment of Health a rtificate of Death	and Mental Hy	giene Reg. No.	2011	11045
Physician	Decedent's Name (First, Middle)	e,Last)			2. Date of Death		3. Time of Death
Medical Examine	Odeniech odpo		Ale City Trans	and another of Dooth	January 2, 2011	County of Death	1856 hrs
	4a. Facility Name (if not institutio Johns Hopkins Bayvie		Baltimore	or Location of Death	46.	County of Death	
Funeral Director	5. Social Security Number unk	6. Sex 7. Age (In yrs. la	Months	Year If Under 24Hrs. Pays Hours Min.	8. Date of Birth (MM/I May 28, 19	Foreign	place (State or unk ntry Maryland
any	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location			T.	10d. Inside City Limits
. A	MD Balt	imore Ess	sex				1 Yes 2X No
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	10e. Street and Number 1652 Riverwoo	d Road	10f. Zip Code 2122		10g. Citiz	en of What Countr	у?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-faher other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status UNK 1 Never Married 2 Ma	1 Yes 2 A No	If Yes, specify Cub	oan, Mexican, Puerto F	Rican, etc.)	14. Race - America White, etc. Specify: Whit	
ural",	3 Vidowed 4 Biv	or Dates: bify only highest grade completed)	1 Yes 2 1	pation (Give kind of wo	ork don - 6b. K	- 11	
72 hou 1 "nat	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working I	life. DO NOT use retire	ed)		
21215-0036 uld be filed within 72 hourn Mental Hygiene, marked other than "natu c event, the Medical Exau To Be Completed	unk 11	unk _	Minister	10 Mathada Nama /	Re3	Ligion	
215-1 be filed and Hyg riked out				Dorothy	Thurman	ourname , arric	-
212 hould be id Ment is mark tic ever			19b. Mailipg Address (Str 1652 River			y or Town, State 7	ip Code)
MD nd 2 sho alth and sm 27 is	O.C.M.E. 20a. Method of Disposition		900 W Ba	LUMOIC DC	Darcimor	ocation - City or To	ira bibbb
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by F	1 Burial 2 Cremation 4 Donation 5 Other Sp	3 Removal from State	rematory or other place)	₹ b. s			
Balt permit. Departi Import injury	21. Si Laure of Fixeral Service Onald S	. Wede Sirector			St; Baltimo		
Physician /Medical	23a. Part I. Enter the disease, or failure. List only one cause			ng, such as cardiac or i	respiratory arrest, shoo	ck, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wound Due to (or as a consequence of)					Deam
	Sequentially list conditions,	b	,				
nine ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of) c.):				
uted nd ransit Examiner	events resulting in death) Last	Due to (or as a consequence of) d.):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex	X UNPENDED	32. If was cutcome of pregn	19b,20a&22perSAB,	,23a,27,28a-f	perME.G913.3	3/28/11.WS	
3760, ficate be g physici s the buri	IF FEMALE: 23b. Was decedent pregnant in the	200. If yes, outcome of pregn		3 Ectopic pregnan	200.	Date of delivery Month Da	y Year
Box 6876: death certificate the attending phy ed for use as the Invsician/M	past 12 months?	4 Pregnant at time of dea					,
b, Box 687(the death certifica y the attending ph ched for use as the	1 Yes 2 No 9 Unk	Ons contributing to death but not re	sulting in the underlying cause	e given in Part I	23e. Did tobacco u	se contribute to the	e cause of death?
Division of Vital Records, P.O. B talor Attending Physiciao: The law requires that the drs after death. In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached artification: To Be Completed by Physicians.		contributing to dealtribut not to	Survive and strying sadd	o givan in acci.	1 Yes 2	Chillian	C100000
ords, w require s been si should b					24a. Was an autopsy		psy findings available inpletion of cause of
Records, The law requires ficate has been sig					performed? 1 ✓ Yes 2 No	death?	2 No
Vital Rec ysiciao: The his certificate director, page			26.Pla	ice of Death (Check or			
f Vit	1 Yes 2 No 27. Manner of Death		ER/Outpatient 3 DOA 28b. Time of Injury 28c. In		Home 5 Residen 8d. Describe how injur	-	
nding Ph th. r: After t e funeral	1 Natural 5 Pendi	(Month, Day,Year)		Yes 2 X No		, 00041104	
//Sior or Attend ter death hirector: n by the	2 Accident Invest 3 Suicide 6 X Could	igation	me, farm, street, factory, office	e building, etc. 2	sh. Location (Street an	d Number or Rura	Route Number, City
Division o spital or Attending nours after death. neral Director: Aft filled in by the func Certification:	4 Homicide determ	(Specify) found at	home	E	or Town, State) 16	land	wood koad
To the Host within 24 ho To the Fun completely i		ysician: To the best of my knowledgeniner: On the basis of examination an	e, death occurred at the time, ad/or investigation, in my opini	date and place, and don, death occurred at t	ue to the cause(s) and the time, date and plac	manner as stated e, and due to the o	cause(s)
To the He within 24 To the Figure Completel	29b. Signature and title of certifier	and manner stated.		nse number		ate signed (Month	
	1 D-m)_		0.0	C.M.E.	Janu	ary 3, 2011	
		who completed cause of death (Item 2		ro Ctroot Deltin-	MD 21222		
State	Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)	Assistant Medical Exam 32 Registrar's Signatur		re Street, Baltimo	Z 1ZZ3		
Registra	1441101	2011 Deneva B.	- park				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ESUS KANGEL 10:30 AM 2011 Medical JANUAR' 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST OCKVILLE MONGOMERY HOSPITAL Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 🗆 F Hours Min (Month, Day, Yea **Director** INFANT 01-01 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Rockville 1 Yes 2X No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 USA 14102 London Ln 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify Mexican "natural" 3 Widowed 4 Divorced Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygier marked other t INFANT INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ignacio Rangel Cruz Paula Hose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Paula Hose - mother 14102 London Ln; Rockville, MD 20853 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Signifure of Find al Service Licenses, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 1 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition HYPOTENSION Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events soulding in death). YPERKALEMI Due to (or as a consequence of Exami PREMATURITY burial-transi XTREME Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached to Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be thin 24 hours after dother the Funeral Direct ompleted filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29d. Date signed (Month. Dav. Year)

State

Registrar

MEDICAL CENTER DRIVE

address of person who completed cause of death (Item 23a) (Type, Print)

9901

32. Registrar's Sigrature

ROST

Year)

WES

31. Date filed (Month, Day,

MID

51461

ROCKVILLE

3

JANUARY

MARYLAND

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2 Tate of Death 3. Time of Death Physician/ INUUL Medical 4a Facility Name (if not institution, give 4c. County of Death cation of Death **Examiner** N/A 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 4 Hrs. **Funeral** 1 XM 2 - F Months Days Min 217-38-1971 67 Yrs. Director MD Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director N/A Baltimore iral", or items 23a or 28a-f s Examiner must be notified MD 1

Yes 2 □ No 10f. Zip Code 21 20 6 10e. Street and Number 10g. Citizen of What Country? 5600 Seward Ave death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc African þ 1 X Never Married 2 Married Yes Maryland 21215-0036 within 72 hours after 2 LJNo If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: "natural" 3 Widowed 4 Divorced Completed Amer. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Photographer Self Profrssional Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Rosalie Johnson Perry Dansby permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Sister y (Lewis) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 Seward Ave., Balt., MD 21206 Bernadette K.Malloy Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Bayview Crematory 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 1/15/11 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHari P. 21. Signature of Funer II Service Licensee Close 5126 Belair Rd, Balt., MD 21206-5105 Approximate In rval Between 23a. Part 1. Enter the disease, or complic that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year rate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform certificate 1 Yes 2 No 25. Was case referred to medica filled in by the funeral director, æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٥ 1 Inpatient ER/Outpatient 3 DOA this f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 2, To the F 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title d License numbe 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00456 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12,2011 Physician/ Month Patricia A. Dunn January 1:44A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Upper Chesapeake Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Pennsylvania Director 174-26-2511 75 Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director 28a-f Florida Collier Naples 1 🗌 Yes 2 💢 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Examiner must be 23a Funeral 4629 Pasadena Court 34109 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc.
White 0 þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify "natural" 3 X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manager AT &T Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James P. Kelly Rita Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra William Dunn 233 Country Club Drive Son Moorestown, NJ 08057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1-13-2011 Bayview Balto. MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licenses 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) recurren neumo Medical Due to (or as a consequence of): Examiner 4 car (avaino ma Surmordistly list in a life on Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ng physician and as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical MSOO5368C5 Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 06613 Medicine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Mnenna hesapea 32. Registrar's Signature State Registrar

101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Lou Davis January 11^{x} 2011 3:15 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Catered Living of Cockeysville Cockeysville Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 L Hours Dec. 13 Director 401-20-7132 88 1922 Kentücky Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Lutherville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8518 Southfield Circle 21093 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ò Baltimore, Maryland 21215-0036 1 Yes X No Specify: 3 Widowed 4 □ Divorced Completed Specify: white d 2 should be filed within 72 hours alth and Mental Hygiene.
127 is marked other than "natura ar traumatic event, the Medical E Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Norman Yarber Grace Ditty 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sue E. Cefalu / daughter</u> Southfield Circle; Lutherville, MD 21093 injury or other 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 N Cremation 3 ☐ Removal from State Other (Specify) Dulaney Valley Mem Gardens 1/14/2011 4 Donation Timonium, MD 21. Signature of Fu 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home. Towson, MD 21204 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Dementio Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pres,... ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Ectopic pregnancy for Day Month Year be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 🗌 No 1 🗌 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one: examiner? 1 Tes ၉ 2 X No 4 D Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) K125808 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 2011 Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11 2011 Year 3:45 PM Otilia Irene Debnar Jan. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9118 Dunloggin Road Ellicott City Howard 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🔀 F Hours Min. Director 90 04/05/1920 075-16-3279 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director Ellicott City 1 Yes 2 X No Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21042 U.S.A. 9118 Dunloggin Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Christina Pencek Frank Kropa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9118 Dunloggin Rd., Ellicott City, MD 21042 <u>Jean Susan Ojard</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o ō <u>=</u> 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 1/15/11 Sunnyside Cem. 4 ☐ Donation 5 ☐ Other (Specify) Tunkhannock, PA 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Anthony P. Litwin F.H. Reynolds St., Factoryville, PA 18419 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ day 5 disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Dav Pregnant at time of death Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe Hospital or Attending Physician: The law 1 Ves 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**/2** No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🔀 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Dav. Year) aN 2011 eddress of person who completed cause of death (Item 23a) (Type, Print) chui ARTZ MD 3512 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month lanuary 534 **Physician** M 2011 Mathilde /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 XF 03/11/1935 75 Austria 216-76-4625 Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location be notified at 1 XYes 2 ☐ No Directo Maryland Harford Belcamp 28a-f 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö with USA 23a 1304 Cranesbill Ct. Unit 202 21017 Funeral an "natural", or items 23: Medical Examiner must I death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Maryland 21215-0036 Specify: Whiite þ 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) In home the 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be a. Department of Health and Mental important: If them 27 is reany injury or other once. Be Maria Kluq Simon Mueller 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 123 Bluebill Ct., Havre de Grace, MD 21078 Michael Dissek (son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State R.A.Ferris & Company 1/6/2011 4 Donation 5 Other (Specify) West Chester, PA 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Inteccrated Hemortha disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Box 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year for Month in the past 12 months? 5 Other (specify) 2 No signed by the a 9 Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 ☐ Unknown 1 Tes certificate has been sig lirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1X Yes 2.5000 filled in by the funeral director. Be Other: 4 \sum Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence al or Attending Physics safter death. 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 2 🗌 No M 1 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide the Hospital 24 hours 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie KP5-000 January 5 2011 Rallerence / Dinas MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

parked

32. Registrar's Signature

Momas

Katherine

31. Date filed (Month, Day, Year)

JAN 1 3 201

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:35AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Woodstock 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Month, Day, Director Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Baltimore MD MUDDISTOCK 1 - Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21163 Koad 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Security D.C. General Hospital 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pisano Joseon >usan 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road E. Esposito Moodstock Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Candallstown, ND Family Cemeter 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Vallann MD 21133 allstenin 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such 🌬 cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequ **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 27. Manner of De 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 2 🗌 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of partifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EUGENE FRANCIS ELLIS 0845 Januar ZOI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore None 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX** M 2 □ F Hours 08/22/1938 ar) Director 215-34-6209 72 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified YY Yes 2 No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 422 East Lake Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2XX Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates. 60-166 3 - Widowed 4 - Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 27 Is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) andscape Designer Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry James Ellis Elizabeth Evert permit. Page 1 and 2 shoul Department of Health and Important; If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 East LAke Avenue Baltimore, Maryland 21212 Patricia McNally Ellis Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) New Cathedral Cemetery :01/15/2011 Baltimore, Maryland nature of Funeral § 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician 20 ord 1 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter chaerlying Examine Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ŕ in the past 12 months? Month signed by the a g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd Baltimore, Maryland 21239 00 250 31. Date filed (Month, Day, Year)-62. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AB OLINDA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 7414 Van Noy Loop Anne Arundel Fort George Meade Social Security Number 7. Age (In vrs. last birthday if Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗾 F Months Days Hours Min 50 1960 Texas Director 466-33-6861 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notitied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No NC Jones Maysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 1462 Belgrade Swansboro Road 28555 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Montine Marie Odom <u>Joe Calvin Dabbs</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1462 Belgrade Swansboro Road Maysville, NC 28555 Anthony Flores. Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/14/11 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 🗌 No 1 🗌 Yes Yes 2 🔽 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 1 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

MICHAEL

31. Date filed (Month, Day, Year

3

445

ise of death (Item 23a) (Type, Print)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eda : 50AM Medical Facility Name (if not institution, give street and number City, Town, or Location of Death **Examiner** County of Death altimore Birthplace (State or Foreign Country)
 MD **Funeral** Social Security Number 7. Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth 1 🗆 M 2 🗶 F Month Min 07/25/1919 91 Yrs. Director 214-03-3415 Usual Residence of Decedent 28a-f show 10a. State 10b. County hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral GRISTMILL COURT, 21208 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced "natural" Completed WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL FEIT ROSE **FABER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA SAMUELSON / DAUGHTER 3120 ENCLAVE COURT, PIKESVILLE, MD 21208 Baltimore. 20a. Method of Disposition
1

→ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) BETH TFILOH CONG. 1/10/2011 BALTIMORE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Chall 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one call e on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Pregnant at time of death 5 Other (specify) Day Year been signed by the s Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has perform 2 🗌 No 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 K Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, ve-State ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 10, LENORA FINGLASS 2011 9:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Min. Days Hours Director 224-22-1690 88 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1 POMONA EAST, #210 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ☐ Yes 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ **TSADORE** POMERANTZ SARAH PRESSMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEON FINGLASS/HUSBAND 1 POMONA EAST, #210, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM: 1/12/2011 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ concer, probable panciety disease or condition Metrinaric Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 🗆 No Yes 2 1 🗌 Yes Be (25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 **N**No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Wher (Specify) 27. Manner of Death 28a. Date of injury To the Hospital or Attending Provithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu D58303

Registrar

DHMH 17 Rev 7/2009

20

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

07.0L

N. Charley ST DENSON MY

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Figure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Da Charles G. Frederick 7:30A M Medical anuary 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto. 9101 Lincolnshire Ct. Apt.M Parkville 7. Age (In yrs. last birthday) 79 yrs. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye **Funeral** 6. Sex If Under 1 Year 9. Birthplace (State or Foreign Days Months Min. 216-28-0573 1**X**□ M 2 □ F Hours Country) Maryland Director August Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Md. Balto. Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 9101 Lincolnshire Ct. USA 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 1951-1955 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Security Supervisor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. George C. Frederick Barbara A. Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lincolnshire Ct. Apt.M Parkville, Md. 21234 <u>Petronilla Frederick</u> 9101 spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dogation 5 XOther (Specify) Entombmen Most Holy Redeemer 1-15-2011 Balto. Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licens Schimunek Funeral Home 9705 Belair Road Nottingham, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset an Doath Immediate Cause (Final Pnysician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal dear 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Month Year detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Director: After this certificate 2 No 2 12 N _ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Direct City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) mn) 071087 2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Joseph Hosp. 7501 Osler Dr. Ste. 102 Towson, MD 21204 Dawn Lemanne

DHMH 17 Rev 7/2009

State Registrar (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death 1715 hrs **Medical Examiner** January 7, 2011 Robert H. Frank 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center **Bel Air** Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Country) MD Min. Months Days Hours Director 2-07-1927 219-22-6971 1 X M 2 F Usual Residence of Decedent ij 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 Yes 2 X No or 28a-f show Fallston Harford Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1203 Hillsboro Ct 21047 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Black or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. 1X Yes White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify. "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 l tent of Health and Mental Hygiene. 21215-0036 Brick 2 Sales Comic 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary L. Bayer George A. Frank 19a, Informant's Name/Relationship (Type, Print) ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD Fallston, MD 21047 1203 Hillsboro Ct Ellen Frank (Wife) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 01-11-2011 Hydes, MD John's Hydes 4 Donation 5 Other Specify 21. Son ture of Funeral Service Linens 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical UNPENDED AMENDED s attending physician for use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d, Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Records. Completed s been s 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed death? 1 Yes 2 ✔ No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other After this 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No hours after death. To the Funeral Director: 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 10, 2011 buthall, ml 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signatur

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frederick John Floyd 2011 January 7:40P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1701 Searles Road Baltimore Co. Dunda1k 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec. 12,1935 Age (In yrs. last birthday, r 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Hours New York **Director** 75 054-28-7654 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1701 Searles Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Yes 2 No Yes, Give 2 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", or þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Steel worker 12 Years Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Noel Stevens Floyd Margaret Voelckel traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Wendy Greiser (Daughter) Dundalk, Maryland 1701 Searles Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Faith Cem. 1/12/2011 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.

Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funer ice Licensee John 7922 Wise Ave Dundalk. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Lanc WEEK & disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year the 9 Unknown g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available 24a. Was an autopsy performed? 1 Yes 2 X No prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural work? 1 🗆 Yes 2 🗆 No injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 42mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

1 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland / Department of Health and Mental Hygiene Info 2011 dhb 1- For State Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2 Date of Death 3. Time of Death Physician/ 1322 hrs **Medical Examiner** Gray Priscilla F. January 9, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland N/A8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director Country) Japan 12/11/1949 524-82-7855 1 M 2 X F 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maine 1 Yes 2 No or 28a-f show Falmouth Aiken Aiken-"natural", or items 23a or 28a-f sho Examiner must be notified at once. death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 04105 65 Falmouth Road 29805 United States Road Funeral 11. Marital Status 12, Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White etc. 1 Never Married 2 Married 2 X No Yes White Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If iten 27 is marked other than "natural", o If Yes, Give Year 4 X Divorced 1 Yes 2 No specify: Specify 3 Widowed á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) narked other than " Legal 5+ Attorney 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Kaiser Edward D. Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1226 Stiefel Road, Aiken, South Carolina 29805 Phillipa F.M. Moon / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 01/11/2011 Baltimore, Maryland Metro Crematory Inc 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Rd., Baltimore, Maryland 21228 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medica Death a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtransit Physician/Medical X AMENDED 1 per me g912 2-7-11 vt ttending physician a r use as the burial -UNPENDED Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Month 1 Live birth 3 Ectopic pregnancy Year Fetal death Dav 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Por 9 Unknown the detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, P.O. á 1 Yes 2 No 3 Probably 4 Unknown Completed s peen si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has page 2 s performed? death? ✓ Yes 2 No After this certificate 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical the funeral director, Division of Vital å Other₄ examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other **✓** Yes ဥ 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c, Injury at Work? 27. Manner of Death Certification: Subject shot self FOUND 1 Natural 5 Pending 1 Yes 2 ✔ No 24 hours after death. Funeral Director: Jan 8, 2011 1123 hrs 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 912 Pulaski Highway, Havre De Grace, MD (Specify) Hotel/Motel Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) January 10, 2011 O.C.M.E e de 0 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State 9ac

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

11-00232	
Deborah Grimm	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible?

State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.													
Physician/	1. Decedent's Name	(First, Middle	,Last)							Date of De Month	Day	Year		3. Time of Death 0930 hrs
Medical Examiner	Debutan	Gri						1	a/D: "	January	8, 2011			บลวบ เมเร
	4a. Facility Name (if 2108 Bostor			umber)		41	b. City, Town, Baltimore		4c. County of Death Baltimore City					
Funeral Director	5. Social Security No. 216-80-45		5. Sex 1 M 2 X F	7. Age (In	yrs. last birt	hday) Yrs.	If Under 1 You Months Da		ours Min.	8. Date of E			Foreign	nplace (State or ntry) MD
	Usual Residence of													
Any Any		10b. County			City, Town		on							10d. Inside City Limits
and show	MD	Baltin	more City	<i></i>	Balti	more								1 XXYes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Nun 2108 Bost		eet				10f. Zip Code 21230				10g. Citizen of What Country?			try?
h with the pers 23s t be noti	11. Marital Status		12. Was De		in U.S.		Decedent of I				No-	14. Race White		an Indian, Black,
fter death wit ", or items? ier must be: y Funera	1 Never Marrie 3 Widowed		1 Yes rced If Yes, Giva Yes or Dates:	2XX ar	No	1	Yes 2XX	lo s <i>pe</i> o	cify:			Specify:	Wh	ite
5-0036 led within 72 hours after they write "natural", other than "natural", the Medical Examiner Completed by	15. Decedent's Ed	ucation (Speci	fy only highest gra				s Usual Occup				16b. K	Cind of Bus	siness/Ir	dustry
5-0036 ed within 72 hour 19/ygiene. the Medical Exar	Elementary/Seco	ndary (0-12)	College (1-4 or 5+)			ervisor				D ₀	ent.	of (Correction
-003 I withi giene. ther th	17, Father's Name (First Middle I		_		Бире			ther's Name	(First, Middle	!			
21215-0036 outd be filed within 7 i Mental Hygiene. in cevent, the Medica To Be Comple	William		Oles					Ма	ry Lo	uraine	McI	ntyre		
21,5 hould b hould b is marl itic eve	19a. Informant's Na	me/Relationsh	ip (Type, Print)											Zip Code) 21060
, MD 2121 and 2 should be fi tealth and Mental i tem 27 is marked traumatic event, To Be	Mary L. M		e / Mothe											rnie, MD
nore, ages l an nt of Hea nt: If ite	20a. Method of Disp		3 Removal f	rom State	cremat	ory or oth			1	Date 12 011			•	ie, MD
Baltimore, permit. Pages I an permit. Pages I an Department of Hea Important: If itee Important: If itee Important: If itee Impury or other transpary or other transpary or other transpary or other transpary or other transpary or other transpary or other transpary or other transpary or other transpary or other transpary or other transpary.		Other Spe			Atlan		Cremato	-	l l		I			
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other fraum	21. Single of Funeral Service Licensee M01220 22. Name and Address of Facility Singleton Funeral & Services, PA 1 2nd Ave SW Glen Burn								& Ci	remation e, MD 21061				
Physician	23a. Part I. Enter the failure. List onl			caused the	death. Do n	ot enter th	e mode of dyir	g, such a	as cardiac or	respiratory a	rrest, sho	ock, or hea	ırt	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (F	Final disease	a. Comp			f Ch	ronic A	1col	ol Ab	use				Death
	or condition resulting		Due to (or as a	a conseque	nce of):									
niner	if any, leading to im cause. Enter Under (Disease or injury the	mediate	Due to (or as a	a conseque	nce of):									
760, cate be executed physician and the burial - transit //Medical Examine	events resulting in o		Due to (or as a	a conseque	nce of):									
760, ficate be executed by physician and the bunal - transit	X UNPENDED		AMENDED	23a,	27 pe	те	g913 3	- 9–1	l vt					
	IF FEMALE: 23b. Was decedent	pregnant in the			f pregnancy						230	d. Date of Month		ay Year
ox 68' ath certificant attending for use as	past 12 months		I Live	birth nant at time	of death		al death :	SECI	opic pregna	ncy	1	MOTILIT	D	ay real
). Box 68 the death certife by the attending toched for use as Physician	1 Yes 2 N	lo 9 🗹 Unki	9 Unkn	nown										
, P.O. Box 68' res that the death certific signed by the attending be detached for use as d by Physician	Part II. Other signif	ficant condition	ons contributing t	to death but	not resultin	g in the ur	nderlying caus	e given i	n Part I.		_			he cause of death?
S, P uires t a sign Id be d				-						24a. Wa				opsy findings available
Records, I The law requires ficate has been sig page 2 should be Completed										aut	opsy formed?	р		ompletion of cause of
Rec The la icate h										1 Yes	2 N		✓ Ye	2 No
ital Recions: The certificate rector, page	25. Was case referr examiner?	red to medical	Hospital:	1	0 FD/0	utpatient		Other	ath (Check o	only one) g Home 5	☐ Basida		Othor	Seena
of Vi Physi er this eral dir	1 Yes 27. Manner of Deat	2 No	28a. Date	Inpatient of Injury		Time of In		njury at V		28d. Describ				Scerie
nding Pl nding Pl th. r: After re funera tion: 7	1 X Natural	5 Pendi	ng (Mont	h, Day,Year)			1	Yes 2	☐ No					
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. 14 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Pertification: To Be Completed by P	1 X Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide Homicide Specify 29a. Certifier Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. 29b. Signature and title of certifier 29d. Date signed (Morth, Day, Year) 1 Yes 2 No 1 Yes 2 No 28f. Location (Street and Number or Run or Town, State) 28f. Loca								er or Rur	al Route Number, City				
Dispital of Carl Dispital of Carl Dispital Dispi														
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certification of Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician									d. e cause(s)					
To con									ed (Mon	th, Day, Year)				
	Dun	with Ru	uthall r	MS			0.0	C.M.E.			Jan	uary 9,	2011	
		. /	who completed cau			r 000	W. Baltim	ore Str	oot Raltis	more MD	21223			
Cont	Pamela E. S 31. Date filed (Mont						VV. Dalum	JIE 311	eet, Daitif	HOIE, IVID	21223			
State Registrar	1 1 1 1	th, Day Year)	11 Sener	ر سد	ignature	we								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Janice Gibbs 09nth 02-2091 Physician/ 13:12 PM Medical 4c. County of Death Hariord 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 - M 2 X F 0 (Month) Day 9977 216-48-2688 63 Matrixand Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County Harford 10a. State Maryland 10c, City, Town or Location Aberdeen 10d. Inside City Limits Directo 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 United States of America Completed by Funeral 103 Riddle Drive permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items
any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Familu Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Ada Ross 17. Father's Name (First, Middle, Last) Joseph McGonigal 198. Mailing Address (Strate and Number of Flural Floute Number Sity of Town State 170 6 9 de) 19a. Informant's Name/Relationship (Type, Print) Edward Gibbs (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
RA Ferris & Co Inc 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State WestChester, Pennsylvania 01-07-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 Sin ur of Funeral Service Licensee 123 South Washington St, Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opert and Death Immediate Cause (Final Physician/ resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant MARY JANICE 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Tyes Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and tit 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month РΜ 2:44 January Jeffrey Randall Gross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Monkton 2014 Blue Mount Rd. 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday Funeral Days 1 🔀 M 2 🗆 F Months Hours New York Director 57 094-46-8108 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No MD. Baltimore Monkton 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral **USA** 2014 Blue Mount Rd. 21111 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 1 Married Completed by Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Electronic Evidence and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Business Owner Investigation Be filed \ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elaine Bernstein Irving Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u> Jyme H. Schafer/ Wife</u> 2014 Blue Mount Rd. Monkton, MD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Co. Towson, MD 4 Donation 5 Other (Specify) 1-12-11 ^{22. Name and} Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204 21. Signature of Fune Service License 23a, Part 1, Enter the disease, or complications that caused the deal enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Doit shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (c _ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and-tran Due to (or as attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been signatures been been been signatures and the second been signatures and the second beautiful to t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 performe Yes 2 N 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 20 NO 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my prowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinent On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier On the basis of exa ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner 3 Certifying Murse Fractioner: To the bes ny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 290 filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gross 12:15 PM 201 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 3505 Claremont BAltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗷 F Months Hours Min (Month, Day, Year) 6 0 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYMOND 1 Yes 2 No TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa If Yes, Give White 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ATeTTelephone PIONEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HORVATH MAK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 Claremont St. Balto Md. 19a. Informant's Name/Relationship (Type, Print) In thony Balto 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ■ Burial 2 ☐ Cremation 3 ☐ Removal from State BAHIMORE, MARY/AND 1-15-2011 AKLAWN Countery 4 Donation 5 Other (Specify) 21. Signatur uneral epice Licensee JOSEPH NZANNINO JEF.H Brito. 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical a consequence Examiner TON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ed by the a Unknown P.O. | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 24 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1. Natural injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°11 7:39 PM Louisa P. Grant January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F (Month, Day, Year) Maine Director Yrs Nov 005-30-5187 76 Usual Residence of Decedent 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Calvert 1 Yes 2 No MD St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20685 USA 2365 Delight St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify Specify Completed 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) florist garden center Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, ည Frank Pitcher Ann Pitcher other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau David Kelley - son 16 Eldredge Rd; Willington, CT 06279 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) In State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ NOS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed and-trans resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 g g 🗌 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA ည 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation the Funeral Director: npleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physicien: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) Name and address of person 100 Hospital RD hristopher MONIDIN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

State of Maryland / Department of Health and Mental Hvoiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Year 2011 Greene 542 PM nessa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Baltimac Secours Bathmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. 1 M 2 St F 1073071966 Country) Maryland Director 44 220-64-3244 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2170 Hollins St. 21223 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Calvin Greene Evelvn Noble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Greene(Father) 2018 McHenry St., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 01/14/11 4 Demation 5 Other (Specify) Baltimore, MD Signature of Juneral Service Lice Joseph H. Brown Jr. FUneral Home PA 2140 N. Fulton Ave.,Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): and -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Onknown Dav Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: 7 24 hours after death. • Funeral Director: After this certifice Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examine 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0063565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) erron 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760 After this certificate has funeral director, page 2: eral Director: After filled in by the funer 24 hours within 2 To the F

Physician/

. Medical

Director

Funeral

Completed by

Be

Examine

Physician/Medical

ğ

Completed

Be

ည

Certificate:

Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

 $Ha+ \overline{\overline{c}}/\overline{c}/\partial$ \overline{c} Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 pmc

✓ DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>011</u> Month Physician/ АМ 9:02 .Tan James Camby Hipsley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3298 Sudersville South Laurel Anne Arundel 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year. Rockvill Days Hours Min 1 🖾 M 2 🗆 F Yrs **Director** 87 214-14-9246 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 K Yes 2 No MD Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20783 USA 1614 East West Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. β 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No rr Yes, Give Year or Dates. 1943–1945 Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Private Industry Master Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Catherine Weaver Laurie Hipsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5613 Sevior Road, Auburn, NY Betty Minturn / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State George Washington Cemetery 1/12/2011 4 Donation 5 Other (Specify) Adelphi, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Const Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes autopsy performed' Chronic Obstructive Lung Disease 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Friend's home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Yes 2 🔀 No မ funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 □ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050951 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 164

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

3 2011

Reva Gill, 6510 Kenilworth Avenue, Suite 2400, Riverdale, MD 20737

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:35 PM Physician/ ANUARY William B. M. Hingeley Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson SAINT JOSEPH MEDICAL CENTER 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Sex 1 M 2 □ F (Month, Day, Days Hours Min Pennsylvania Months 87 189-14-1724 May Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho Director 1 🗆 Yes 2 💢 No MD Towson Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21204 USA 1017 Kenilworth Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: white 3 🕅 Widowed 4 🗆 Divorced Year or Dates be filed within 72 hours ntal Hygiene.

ed other than "natura sevent, the Medical E. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Officer Insurance 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be file of Health and Mental Hitem 27 is marked of ျှ Sarah Rogers Benjamin N. Hingeley other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 409 Washington Ave. Suite 707; Towson, MD 21204 P.R. David J. McDonnell 20a. Method of Disposition

1 Bunal 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o Oulaney Valley Mem Gardens 1/14/2011 Timonium 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Cor 1050 York Road 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC ARKHYTHMIA disease or condition resulting in death) Medical **Examiner** ENTRICULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) CAR DIOMYOPATA Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an BRONCHIECTASIS autopsy performed? Yes 2 N page 2 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manger of Death 1 Natural 2 Accident injury work? 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier D59283 who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 ADDO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12^{Day} Physician/ Month 2011 Hamme1 9:30 A M Dolores January Catherine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore <u>Baltimore</u> Oak Crest If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Sept. 30 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Mary land Director 219-01-6314 93 Sept. Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 🗶 No <u>Maryland</u> Baltimore Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 8820 Walther Blvd. U.S.A. Apt. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher High School Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is mediany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Poffe1 Gladvs C. Litz Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 <u> 3 Nuthatch Court</u> Cockeysville, Maryland Gloria Jean Hammel Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-17-2011 Mt. Maria Cemetery Towson 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. urero Funeral Service Licensee Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Ph_sician/ Coronary arky disease or condition resulting in death) Medical Due to (or as a sequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence on cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonary HTN, CHF, Hyperknisme Cardiovaxular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dscare 24a. Was an performed 2 🗌 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 34 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number R171944 HORAUN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michealle G. Hormson CENP NSN 8800 Walther Blvd, Parkville MD 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1/15/11

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Howell 2011 4:30 P M Virgil January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Essex 802 N. Marlyn Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. October 16, 1919 Ashe, NC 215-12-4656 **Director** 91 Usual Residence of Decedent Show 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore Essex Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21221 USA 802 N. Marlyn Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Minister Church 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Carrie Mae Houck Romer Howell permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 802 N. Marlyn Avenue, Essex, Maryland Ora Lee Howell Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State January cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State Holly Hill Memorial Grons. Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 of Funeral Service Lice Conneity Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 skli 2 23a. Part). Enter the disease, or complimitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinc k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia 5 years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Infections 2 weeks Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Sepsis 2 weeks attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 5 Other (specify) 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No Yes 2 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🗹 No 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this e Hospital or مدت. ان 24 hours after death. ان عا Director: After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 🗹 Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 3030. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown N. Eutaw 844 St. Baltimore, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

HON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Stephen Hitchner 10:30 PM January 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 921 Winding Way Salisbury Wicomico 8. Date of Birth (Month, Day, Year) Feb 4, 1916 9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 1 X M 2 □ F Feb 4, 198-12-7692 94 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Wicomico Salisbury 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21804 921 Winding Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) veterinarian animal care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Rockefeller Sarah Ballinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Hitchner 807 Chumleigh Rd; Baltimore, MD 21212 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signa III of Fun I Service 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

and

the attending physician

certificate

this

after death

within 24 hours a

To the Funeral C

Physician

/Medical

Funeral Director

Be Completed by

ဥ

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Marchall Eventuary.

burial-trar the for use cate has been signed by the page 2 should be detached Examiner

Physician/Medical

ģ

Be Completed

Certification: To

Medical

filled in by the funeral

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

		.d							
IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year								
Part II. Other significan	at conditions o	ontributing to death but not res	ulting in the underlying	g cause given in Part I.		use contribute to the cause of death?			
				-	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred t	o medical			26. Place of De	eath (Check only one)				
examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)			
2 Accident	Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injur	ry occurred			
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street ar City or Town, State	 Location (Street and Number or Rural Route Number, City or Town, State) 			
29a. Certifier 1 (Check only one)	Certifying Ph Medical Exam	ysician: To the best of my knoniner: On the basis of examination	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause(s curred at the time, date an	s) and manner as stated. d place, and due to the cause(s)			

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAN 32. Registrar's Signature

29c. License number

1415 SDIVISION sheet

29d. Date signed (Month, Day, Year)

STEISBURY MD 218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 January P^{M} 1:50 Gary Richard Henkelman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month Day, ec 20, 1 🕅 M 2 🗆 F Months Days Hours Min Washington DC **Director** 215-66-5616 1954 Dec Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1812 Windjammer Way USA 20879 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed er than "natur the Medical I 16b. Kind of Business Industry unk 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) and Mental Hygiene. electrician Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Gordon Henkelman Clara Mae Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gail McAllister - sister 6087 Carpenter St; East Petersburg, PA 17520 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State 22. Name and Address of Facility State Anatomy Board Director 555 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ liver end Stape disease or condition resulting in death) Medical Due to (or as a construence of) Examiner hepatitis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hunknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🕅 No မ 1 Junpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide ector: / by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) anetro MD 0006 7386 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Drive Mary land 20850 center Sonia John, MD 9901 Medical 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

R

5

ANKAR

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760

RICHARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1600 VAN HOOK LAND ALEXANDER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CROSS HOSPITAI SPRING MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Country **Director** Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City. Town or Location at 10a. State Director Examiner must be notified 1 ¥ Yes 2 ☐ No OTOMIHZAW DC 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number 23a Funeral NE 2000 SVA 904 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married "natural", or ģ ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. Specify: Specify: BLACVC 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT NFANT Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မှ HAILES KENNETH VAN HOOK KATHON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other tran WASHINGTON ,000? 904 DC 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Sig alure of Funeral Funeral Pervice Licen Wade Director m 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediale Cause (Final Ph_sician/ PREMATURIT . 6 WKS disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** HORIOAMNIONI Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to tur as a consequence ufi and -transit that initiated events resulting in death) Last Due to (or as a consequence of) burialthe attending physician hed for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2. autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 **V** No 1 🗌 Yes 1 MInpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier D44 01, 05, 2011 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p GLEN RD FOREST NAU 1200 31. Date filed (Month, Oay, Year) 32. Registrar's Signature State 3 Registrar Barke

11-00093	
Lucy Hall	

ucy Hall		State of Maryland / Department of Health and Mental		gible.	00483
,		1- For State Certificate of Death	• -	the No. 1 1	
Physic	ian/	1. Decedent's Name (First, Middle,Last)	2. Date of Deat		3. Time of Death
ledical Exam	ine	Ducy Hall	Month January 3,	Day Year 2011	0730 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of Deat	h
;=		Peninsula Regional Medical Center Salisbury 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Ulas I P Data of Dist	Wicomico	-th-l (Ot-1
Funeral Director		Months Days Hours	Min	h(MM/DD/YYYY) 9. Bi Forei	gn
		218-48-6579 1 M 2 F 66 Yrs. 100 100 100 100 100 100 100 100 100 10	May 13	, 1944	ountryMaryland
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.		MD Wicomico Pittsville			1 Yes 2 K No
Maryl: 28a-f d at o	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	intry?
h the] 3a or	₫	5014 Powellville Road 21850		USA	
th wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married 15. Was Decedent of Hispanic Origin? 1 Fyes, specify Cuban, Mexican, Pue		14. Race - Ame White, etc.	rican Indian, Black,
er dea		1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Whi	te
urs afi tural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	of work done	16b. Kind of Business	
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	retired)		
yithin ene.	Completed	12 2 nurse		healthc	are
filed in Hyging of the			ame (First, Middle, M	laiden Surname) . Steelman	
212 uld be Menta mark	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			e. Zip Code)
AD 2 short and 27 is matri	-	Tina Taylor - daughter 322 Glen Ave. #322			, , , , , , , , , , , , , , , , , , , ,
re, I and I healt ritem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Pages lent of int: I		4 X Donation 5 Other Specific	:		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient April and Emperature of Health and Mental Hygient April and the file and the		21. Singure of Fu Service Licensee on ald S Wade, Director 22. Name and Address of Facility St	ate Anato	omy Board	
		055 W. Baltimore	St; Balt	imore, MD	
Physician /Medical		23a. Pirt I. Enter the divides, if complications that it used the death. Do not enter the mode of dying, such as cardia fair re. List only one cause on each line.		st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications of parkinson's disease or condition resulting in death) Due to (or as a consequence of):	e		Death
		Sequentially list conditions, b			
	iner	if any, leading to immediate Due to (or as a consequence of); cause. Enter Underlying Cause			
=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - trans	ical E	d.			
	edic	\square UNPENDED \square AMENDED 23a,27,per me,g915 6-2-11 sm			
30x 68760, death certificate be attending physicial for use as the buria	N/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	anancy	23d. Date of deliver Month	y Day Year
th cert	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
ाह है ु	Physician/Med	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	00 - D: L(-)		
ires that the signed by the detach	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	
ords, w require s been sig	Completed				itopsy findings available
Cords law requi has been e 2 should	n du		autops perform	ned? death?	completion of cause of
Retificate	S	25. Was case referred to medical 26.Place of Death (Che	1 Yes 2	No 1 V	es 2 No
of Vital Records, ag Physician: The law requir the true requir wher this certificate has been some all director, page 2 should	o Be	examiner?		Residence 6 Other	r:
ing Ph	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
ttendi death.	atio	1 X Natural 5 Pending 2 Accident Investigation (Montin, Day, Year) 1 Yes 2 No			
Division of 'ppital or Attending Phous after death. ceral Director: After tfilled in by the funeral	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		ral Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	S	4 Homicide determined (Specify) 29a. Certifier 1 Certifier Physician: To the best of my knowledge death occurred at the time date and place a	1		
To the Hosp within 24 hoi To the Fune	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre			
To ron	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo.	
		There III have To O.C.M.E. OGM	-	January 4, 2011	
		30. Name and address of person who completed cause of dyal (Item 23a)			
		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, MD	21223	
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 00484 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WALTER JOHNSON January 2011 0010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE HOSPITAL HARFORD CO AIR. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 XM 2 □ F Months Hours Min AUG 18 MISSISSIPPT Director Yrs 92 426-30-8433 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 28a-f 1 Yes 2XXNo MARYLAND HARFORD CO ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 408 DORSEY STREET 21001 U.S.A. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married If Yes, Give Year or Dates.44/46 1 Yes 2 No Specify: "natural", Specify: BLACK 3XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade NURSE AIDE PERRY POINT VA other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ and 2 should be JESSIE JOHNSON MILLIE JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce, Melvin L. Johnson/Nephew 487 Windemere Dr., Aberdeen 21001 Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARFORD MEMORIAL 01-18-11 HARFORD CO, MARYLAND 21. Signature of Funeral Service Licens 22. Name and Address of Facility WILLIAM 321 S. J C BROWN COMM FUNERAL HOME-HARFORD, P.A. PHILADELPHIA BLVD, ABERDEEN, MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? To the Hospital or Attending Physician: The law requires that the death Month Day Year Yes 2 No 9 Unknown g Unknown þ Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page After this certificate 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 6+1 30. Name and address of person who cor of death (Item 23a) (Type, Print) (001 State Registrar

0

0)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene state Amend Item 25 per me,g911,01/12/2011dhb Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month encora PM Ohnsoz 6:10 Medical Januar 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death altimor N/A Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 F Days Months Hours 1^{1/2}/¹/1²/₅,/²/1⁹55 Maryrand Director 214-64-0910 55 Yrs. Usual Residence of Decedent shov 10a State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No N/A Baltimore MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Bentalou st. 21216 U.S.A. Ν. items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. ö 1 ☐ Yes 2 🔀 No If Yes, Give ò 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", 3 Divorced Specify: Completed Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Check Processor Bank years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o မ Page 1 and 2 should be ment of Health and Menta <u>James E. Johnson</u> Mary L. Petty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Neal Johnson(brother) 2473 Golders Green Ct., Baltimore, MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/12/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Arbutus Cem. 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ iac disease or condition Medical resulting in death) Examiner quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence 6 AL EXAMINER CERTIFICATION APPROVED BY CO. and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy disease perform death? Lular 2 No 1 Yes 2 No 1 Yes Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of ce 29d. Date signed (Month. Dav. Year) 04 who completed cause of death (Item 23a) (Type, Print) Ow MC 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8perFH, G911,1/13/2011 WS State of Maryland / Department of Health and Mental Hygiene / for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 13:47 ากรูขก 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore City 8. Date of Birth 12/20/19469. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 XF Months Hours Director 28a-f shov 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Funeral Director HiMORE 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Worker Be 17. Father's Name (First, Middle, Last) ဂ္ Keatrice 2 should be telle off. Page 1 and 2 since of Health and 2 m 27 is 19b. Mailing Address (Street and Number or Rural Route Numb Baltimore, atient 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Nationa 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Sarvice Licensee 22. Name and Address Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ₹nysician/ disease or condition resulting in death) Medical a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director: After this certificate has been signed by the attending physician and Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month 1 ☐ Yes ∠ ₹ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 1 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **N**o Hospital Other: 욘 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ma January Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner last birthday) QQ Yrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Min. Hours Jamaica Director 28a-f show 10b. County 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Specify. "natural", 3 Widowed 4 □ Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Segonday (0-12) College (1-4 or 5+) and Mental Hygiene. 27 is marked other r traumatic event, Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve ၉ Informant's Name/Relationship (Type, Print) City or Town lames Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee WO 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a contequence of): Examiner Seauchtielly list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of that the death certificate be executed the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Į Year 5 Other (specify) ned 1 the g Unknown g 🗌 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗆 Yes 2 🔼 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 2 🗌 No Investigation Accident Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dolling 5601 31. Date filed (Menth Paye Year) . Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan 12 201 Pay 3 230A M Harry Jacob Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Solomons Solomons Nursing Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Feb. 28 Min. 1**火** M 2 □ F 219-10-6036 84 1926 MD Director Usual Residence of Decedent shov 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director or 28a-f sl Solomons 1 Yes 2 X No Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a o USA Funeral 20688 Box 1481 P.O. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ¥ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: leted White 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Compl (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Maintenance 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Jackson William F. Jacob 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Jacob /wife P.O.Box 1481 Solomons MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1
Department of
Important: If it
any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gardens of Faith 1/17/11 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. 21. Signal e A Funeral Service Licensee Connelly Funeral HOme of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCLEROTIC HEART DISEASE Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of if any hading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Yes 2 No ed by the a detached t 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ ALZHEIMERS SEVERE amen 2 No 3 Probably 4 Unknown 1 Yes cate has been sig Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certific eted filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number

Registrar

DHMH 17 Rev 7/2009

State

ANWAR

31. Date filed (Month, Day, Year)

parke

MD. SUITE 300

32/ Registrar's Signature

130 HOSP. RD. PRINCE FREDERICK MD20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUNSHI

JAN 13 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 10, 2011 6:15 P M **ELCHANAN JAKOBSON** Medical 4b. City, Town, or Location of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE N/ASocial Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 05/16/1920 1 XM 2 □ F 90 Director 220-96-1691 LATVIA Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 ☐ Yes 2x No BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1500 BEDFORD AVENUE, 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Divorced 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SALESMAN TEXTILES Be permit. Page 1 and 2 should be filed. Department of Health and Mental He. Important: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 YENKEL JAKOBSON CHANA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1870 AUTUMN FROST LANE, BALTIMORE, MD MIRIAM KRUPITSKY/DAUGHTER 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/12/2011 HAR SINAI CEMETERY OWINGS MILLS, MD Sign ture of Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or Examiner VASCUlar Riphera Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifics eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tyes 2 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide 5 Pending work 1 Tes 2 \square No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE JAV630 2835 31. Date filed (Month, Day, Year)

JAN 1 3 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 00490 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Shirley Kaufman 20°1′1 9:12A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ivy Manor Assisted Living Howard Ellicott City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** New York 1 🗆 M 2 🕱 F Months June I, Year) 936 130-28-9844 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Howard Ellicott City 10e. Street and Number 10f, Zip Code ö 10g. Citizen of What Country? Funeral 2817 Montclair Drive 21043 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iten Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene.
I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Electrical 1 and 2 should be filed wi of Health and Mental Hygin i item 27 is marked other other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herman Kaufman Sarah Zimbalist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Zeitler (Niece) 5014 Coblestone Court Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ± 5 permit. Page Department of Important; If any injury or once. 1-10-2011 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Priset and Death Immediate Cause (Final disease or condition METASTATIL Breage Canara Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No After this certificate has been si funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th Certificate: 5 Pending injury 1 X Natural Accident Investigation completed filled in by the Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi January 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ida Virginia Kerslake 01-08-2011 Year 0200 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakcrest Village Baltimore Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) MD 1 □ M 2 🗓 F Days Hours 11-30-191 Director 221-30-2636 92 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd #333 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Rodney Ida Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Lynn Pitts (Daughter) 445 Patterson Mill Rd Bel Air, MD 21015 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 01-10-2011 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Defining in Figure 1. We have a state of the cause(s) and manner stated as a least of the cause(s) and manner stated as a least of the cause(s) and manner stated as a least of the cause(s) and manner stated as a least of the cause(s) and manner stated as a least of the cause(s) and manner stated as a least of the cause(s) and manner as stated. (Check only one) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 WALTHER Blud. State Registrar Bark

/ DHMH 17 Rev 7/2009

4

N

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 5:14 PM Physician/ oudens 201 anua Medical ility Name (if not institution, give stree 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** Washington ledica enter 7/en Trunde Daltimore thue Social Security Number If Under If Unde 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral 1 X M 2 □ F Months Davs Hours (Month, Day Year) Country) Maryland Sept. Director 217-24-5253 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c, City, Town or Location Director 1 🗆 Yes 2 ី No Glen Burnie MD Anne Arundel Co. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21061 22 Ferndale Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. X Yes 2 ☐ No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Bakery Pan Stacker yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Washington Georgianna William Joshua Loudenslager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21230 2005 Grinnalds Avenue Baltimore, MD Ms. Wendy J. Loudenslager/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Park :01/17/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia ^onysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Jepsis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 Other: 1 Tyes 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending 1 🗌 Yes 2 🖵 No Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 2011 person who completed cause of death (Item 23a) (Type, Print) Ð 31. Date filed (Month, Day, Year) 32. Registrar State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 09:30 M Thomas LEISHEAR WARREN JAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY HOWARD COUNTY GENERAL HOSPITAL COLUMBIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1xx M 2 □ F Days Hours Min 82 578-38-4921 MD Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Howard Savage 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 8409 Woodward Street 20763-9664 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 → Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Korean Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Owner-Operator Bus Company traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret E. Redmiles Arthur E. Leishear, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Jane Leishear - wife 8409 Woodward Street, Savage, Maryland 20763-9664 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem Park: 01-15-2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Lice Mar MMP., Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ RIGHT PNEUMOTHORAX (TENSION) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE SIP TRACH Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit PNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ACUTE RENAL Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an HYPERTENSION autopsy performed? Yes 2 1 COPD 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes 2\ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP Myin ly JAN, 11, 2011 D0064760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARTER DRIVE SUITE #310, COLUMBIA, MD 10710 VANCHA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 11-00274 David E Link, Jr 1- For State

	Registrar		Ochincat	e or Dearr		Re	g. No.	
Physician/ Medical Examine	David	Edward Link				2. Date of Deat Month January 9,	Day Year 2011	3. Time of Death 1415 hrs
		t institution, give street and nu y General Hospital	mber)	4b. City, Town, Columbia	or Location of Death		4c. County of Dea Howard	th
Funeral Director	5. Social Security Numb 220-56-836		7. Age (In yrs. last birthda 54		ear If Under 24Hrs ays Hours Min	_	irthplace (State or ign ountry) MD	
21215-0036 hould be filed within 72 hours after death with the Maryland hold be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f ahow any note event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Usual Residence of Der 10a. State 10b MD 10e. Street and Number 2858 Jess 11. Marital Status 1 Never Married 3 Widowed 15. Decedent's Educal Elementary/Seconda 12 17. Father's Name (Firs David Edw 19a. Informant's Name/I	Cedent Cample Arundel Fine Arun	edent Ever in U.S. 1 prces? Y No r le completed) 16a. De dur Ma	Location Jessup 10f. Zip Code 20 3. Was Decedent of If Yes, specify Cut 1 Yes 2 X I cedent's Usual Occuping most of working Internance Mailing Address (Str 331 Brock	Hispanic Origin? (Span, Mexican, Puerto No specify: Pation (Give kind of virte. DO NOT use reti Supervis 18 Mother's Name Mar Breidbyeber or F Ridge Roa	vork done red) Or (First, Middle, My Ann Varial Route Num	Dg. Citizen of What Cou USA 14. Race - Ame White, etc. Specify: 16b. Kind of Business Balto. Cou taiden Surname) Wolf ber, City or Town, Stat 1p, MD 2079	10d. Inside City Limits 1 Yes 2 No Juntry? Incan Indian, Black, White Vindustry Intry Club e, Zip Code)
Balti permit. Departu Import injury c	4 Donation 5 1	Other Specify: a) Service Licensee	om State crematory Trinity		1/1 ess of Facility aufman Fu ington BI		Waldorf, Ome at MMP,	Maryland
Physician Medical Examiner				nter the mode of dyin	g, such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
insit	Sequentially list condition if any, leading to immediate. Enter Underlyin (Disease or injury that is events resulting in deat	diate Due to (or as a graph of the diagram of the diagram). Due to (or as a diagram) Due to (or as a diagram)	consequence of):					
o, b, e executed sician and ourial - transit	UNPENDED	d. X AMENDED	10b,19b,per	 FH,G912,2,	/9/2011,WS	 3		
ion of Vital Records, P.O. Box 68760, treading Physician: The law requires that the death certificate be executed beath. To receive this certificate has been signed by the attending physician and vithe funeral director, page 2 should be detached for use as the burial - transiation: To Be Completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent preg past 12 months? 1 Yes 2 No 9	gnant in the 23c. If yes, of 1 Live bit 4 Pregnate Unknown 9 Unknown	outcome of pregnancy rth 2 ant at time of death 5 wn	Fetal death 3 Other (Specify)	Ectopic pregna		23d. Date of deliver Month	y Day Year
cords, P.O. law requires that the has been signed by 2.2 should be detach mpleted by P. mpleted by P.		nt conditions contributing to	death but not resulting in	the underlying cause	given in Part I.	1 Yes		bably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	25. Was case referred to			26.Pla	ce of Death (Check o	autops perform 1 Yes 2 only one)	ned? death?	es 2 No
F Vit Physici or this or ral dire	examiner? 1 ✓ Yes 2	No Hospital: 1 Ir	npatient 2 🗹 ER/Outpa	atient 3 DOA	Other Nursing	g Home 5 🗌 F	Residence 6 Othe	r:
Division of spital or Attending Phours after death. Beral Director: After if filled in by the funeral Certification: T	27. Manner of Death 1 Natural 5 2 Accident	Pending Investigation 28a. Date FOUND: Jan 9, 20	Day, Year) FOUND 011 1322 hr	D: 1	Yes 2 No	Subject struc vehicle	ow injury occurred ck a wire while rid	
Divisior Hospital or Attent 24 hours after death remertal Director: rety filled in by the al Certificatic	3 Suicide 6	Could not be	of Injury - At home, farm, Woods	street, factory, office		or Town, Staument or Town, Staument Unknown, Elkri		urał Route Number, City
Divis To the Bospital or At within 24 hours after d To the Funeral Direct completely filled in by Medical Certifics	one) 2 Med	tifying Physician: To the best tical Examiner:On the basis o and manner st	f examination and/or inve	stigation, in my opinio	on, death occurred at	the time, date a	nd place, and due to th	ne cause(s)
•	29b. Signature and title	of certifier			.M.E.		29d. Date signed (Mo January 10, 201	
12	30. Name and address of Donna M. Vince	of person who completed causenti, MD Assistant M	e of death (Item 23a) edical Examiner	900 W. Baltimor	e Street, Baltim	ore, MD 212	223	
State Registrar	E B B B B B B B B B B B B B B B B B B B	ay, Year) 32, Reg	gistror's Signature	,				

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00495 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 ear Physician/ Month 12:20 P M January Nancy Buseman Leahy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec. 16, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. West Virginia Yrs 1932 **Director** 218-28-0085 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits Director 1 ☐ Yes 2 🏹 No Timonium MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ıral", or items 23a oı Examiner must be Funeral 304 Ridgely Road 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 XMarried 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Ruby Kiernan Bill Buseman Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 304 Ridgely Road; Timonium, MD 21093 John I. Leahy, Sr. / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gardens | 1/14/2011 Timonium, MD 21. Signature of Funeral Se vio 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 49 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 **X** No 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 Yes 2 No 24 hours after death Funeral Director: A Accident Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one) 29b. Signature and title of certif 29d_Date signed (Month, Day, Year, 105 MO 30. Name and address of person who completed cause of death (Item 23a) Type, Print) ERNESTINE WRIGHT, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Class 32 Registrar Signatural State Registrar

DHMH 17 Rev 7/2009

p.n.

17:70

11-00283 Larry Lawrence

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 00496 1- For State Certificate of Death

Physici	an/	Decedent's Name (First, Midd	ile,Last)							2. Date of D	eath			3. Time of Death
Medical Exam		Larry The	omas	Lawrence	70					Month January	9 201	Year		2109 hrs
		4a. Facility Name (if not institution				14	b. City, Town,	or Location	of Death	y		c. County or	f Death	
		Johns Hopkins Bayvi	ew Medical Cen	iter			Baltimore							
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birt	hday)	If Under 1 Y	ear If Und	er 24Hrs.	8. Date of	Birth(MM.	/DD/YYYY)	9. Birt	hplace (State or
Director		214-80-9488	1X M 2 F	1)		Months D	ays Hours	s Min.	1			Foreign	1
			1 M 2 F	48		Yrs.		l	ــــــــــــــــــــــــــــــــــــــ	01/4	22/19	102	COL	^{intry)} Maryland
á		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town	or Location	on.							10d. Inside City Limits
W a														1 Yes 2 X No
Maryland 28a-f show d at once.	to		timore	I	Dund	alk								
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Director	10e. Street and Number					10f. Zip Code	1			10g. Cit	izen of Wha	at Coun	try?
h the 3a oi otifi	⊡	3425 Yardley I	Drive				2122	2			U.	S.A.		
n with	Funeral	11. Marital Status		cedent Ever in U	J.S.		Decedent of es, specify Cub				No-	14. Race - White		can Indian, Black,
deatl or ite	5	1 X Never Married 2 M	larried 1 Yes	2 X No			o, specifical	an, moxican	1, 1 401101	(loan, etc.)		vviiito,	, 010.	
after al",	ý		vorced If Yes, Give Yes or Dates:			1	Yes 2∑ I	No specify:	:			Specify:	V	hite
ours	Þ	15. Decedent's Education (Spe	ecify only highest grad	de completed)			s Usual Occup st of working I				16b. I	Kind of Bus	iness/Ir	ndustry
7 - 7	Completed	Elementary/Secondary (0-12)	College (*	1-4 or 5+)		daning inc	ot or working i		doc rounc	,				
O3 or thin or the	E	11				Nev	er Worl	ked				Neve	. Wo	rked
5-00 led wil Hygien other		17. Father's Name (First, Middle	, Last)					18.Mother	r's Name (First, Middle	e, Maiden	Surname)		
21215-0036 hald be filed within 7 Mental Hygiene. marked other than	Be	Thomas V:	incent	Lawre	ence)		Car	olyn			Wit	tte	
D 21 hould nd Me is ma	유	19a. Informant's Name/Relations	ship (Type, Print)		191	o. Mailing	Address (Str	eet and Nun	mber or Ru	ural Route N	umber, C	ity or Town	, State,	Zip Code)
MD d 2 sho lth and a 27 is		Carolyn Lawrer	nce / Moth				Yardle		re, D	undal				
ore, MC is 1 and 2 sl of Health an Hitem 27		20a. Method of Disposition 1 Burial 2 Cremation	- a			of Disposit	ion (Name of e	cemetery,		Date	20c.	Location -	City or	Town, State
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and IN Important: If item 27 is in injury or other traumatic		4 X Donation 5 Other S	_			•	ts Regis	tra z	01/1	2/201	1 11	220110	r 1	Maryland
		21. Signature of Funeral Service		I A	iatui	22. Na	ame and Addre	ess of Facility	y An	atomy	Gift	s Rec	rist	<u>Marylanu</u> rv
Balt permit. Depart Import injury	Į.	KOTT	+)	_		752	22 Conn	ellev	Dr.	Ste.	Ρ.	Hanov	er.	MD 21076
Physician		23a. Part I. Enter the disease, or		aused the deatl	n. Do no									Approximate Interval
/Medical		failure. List only one cause	A71	ol Into	zion	tion	Comp 1	icated	l Rw	Hymoth	.ermi	ia		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence		LIOII	СОМРТ	LCacco	L Dy	пуросі	СГШ	La		
		Conventially list conditions	b.		,									
	힐	Sequentially list conditions, if any, leading to immediate		consequence	of):									
	힘	cause. Enter Underlying Cause (Disease or injury that initiated	С		_									
ed sit	Examine	events resulting in death) Last		consequence	of):									
68760, certificate be executed ding physician and e as the burial _ transit		5	d	230 27	28	2_f 1	oer me	σQ12	2_2_1	1 vt				
D, be ey siciar	an/Medical	X UNPENDED	AMENDED	234,21	,20	a-r	Jer me	gjiz .	Z-Z-J	LI VL				
68760, certificate be iding physici	Š	IF FEMALE: 23b. Was decedent pregnant in the	-	outcome of preg							236	d. Date of d	-	
g di fi g		past 12 months?	I LIVE D	nant at time of d	eath -	Feta		Ectopic	c pregnan	cy		Month	D	ay Year
Box ne death o the atten	ysic	1 Yes 2 No 9 Uni	known 9 Unkno		0	Oth	er (Specify)							
the o	Physici	Part II. Other significant condit	tions contributing to	o death but not	esulting	j in the ur	derlying cause	given in Pa	art I.	23e. Dio	tobacco	use contrib	ute to t	ne cause of death?
Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for u	۵									1 🗆 Y	es 2	No 3	Proba	ably 4 🗸 Unknown
dayire	Completed									24a. Wa	is an	I 24b. W	ere aut	opsy findings available
COF law re has be	ᆲ									aut	opsy formed?	pri		empletion of cause of
Zec The Dage	[1 Yes			Yes	2 🗍 No
tal Rection: The certificate ector, page	Be	25. Was case referred to medica examiner?					26.Pla	ce of Death	(Check or	nly one)				
Division of Vital Records, ral or Attending Physician: The law requirers after death. To Director: After this certificate has been sited in by the funeral director, page 2 should be as the property of the funeral director, page 2 should be a should be a second to be a should be a second to be a should be a second to be		1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸	ER/O	utpatient	3 DOA	Other ₄		Home 5		ence 6	,	
1 of Vi		27. Manner of Death	28a. Date (Month	of Injury , Day, Year)	28b.	Time of Inj	ury 28c. In	jury at Work	? 2	8d. Describ	e how inju	ury occurre	Su	oject drank osed to lov erature
teath.	읥	Natural 5 Pend 2 X Accident Inves	dina	-9-11	fd	8:28	pm 1	Yes 2 🗶	No C	envir	onnei	itälö	temp	erature 10
Vision by	<u>≅</u>			e of Injury - At h				building, et						al Route Number, City
Division pital or Atten ours after death neral Director	Certification:		rmined (Specify)	fro	nt p	orch				7038	Belc]	lare I	Rd.	Dundalk, M
Hosp 24 ho Func rely fi	2	29a. Certifier (Check only 1 Certifying Pl	hysician: To the bes	st of my knowled	lge, dea	ith occurre	ed at the time,	date and pla	ace, and d	ue to the ca	use(s) an	nd manner a	as state	d.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	edical	(51,551,511)	miner:On the basis	of examination a										
P. ≥ P. S.	Š	29b. Signature and title of certifie	and manner s	ialeu.			29c. Lice	nse number			29d.	Date signed	d (Mon	th, Day, Year)
		ana 72					0.0	M.E.			Jan	uary 10,	2011	
	- 1	30. Name and address of person	who completed a	on of dooth /lt	2221						1	, ,		
			sistant Medical E		,	/. Baltin	nore Street	. Baltimo	re, MD	21223				
		04 B 32 61-3 44 # B 37 1	Who D	atalanda Otalan				.,	-,					

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death dent's Name (First, Middle 3. Time of Death Month Month Physician/ Medical or Location of Death cility Name (if not institution, give street and number 4b. City, Town 4c. County of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** June 24, Months ^{Year)}1924 Maryland 217-12-0470 Yrs. 86 Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director Dundalk 1 Yes 2 XNo Baltimore Maryland 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a USA 21222 96 Shipway Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural" 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. If item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C&P Telephone Engineer 12 years Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ပ Ruth Rhodes Charles Lawton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Marion Lawton 96 Shipway, Dundalk, Maryland 21222 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State January 14 cemetery, crematory or other place) ☐ Burial 2 TKCremation 3 Removal from State Baltimore, Maryland Bayview Crematory 2011 4 Donation 5 Other (Specify) Signature of Foneral Service Lice Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each ine. Approximate Interval Between Onser and Death Immediate Cause (Final ^chysician/ disease or condition resulting in death) Medical consequence of) Examiner Sequentially list conditions, Examiner cause (Disease or iinjury Due to for se a ponescuance on has been signed by the attending physician and ge 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 X No death? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director, Be (26. Place of Death (Check only one) Hospital Other: Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Manuar of Death 28a. Date of injury (Month, Day, Year) 8b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending injury Natural 1 Yes 2 \square No cident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and to 0-0061115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Hardin

3 2011

Day, Year,

Pauk

MU

Eastern Avenue

4940

32. Registrar's Signature

21224

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.	20101
State of Maryland / Department of Health and Mental Hygiene 20	0049
0 45 -1 50 4	

		1- For State Certificate of Death Registrar Reg. No.				
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day January 7, 2011	3. Time of Death 1323 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De 4d. County of De 4d. County of De 4d. County of De 4d. County of De 4d. County of De	ath			
Funeral Director		212-58-5703 1×M 2 F 57 Yrs. 01/10/1953	Birthplace (State or reign Country)			
faryland 28a-f show any 1 at once,	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location BALTIMORE	10d. Inside City Limits 1 Yes 2 No			
the Mary 3a or 28a.	Director					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f abor other traumatic event, the Medical Examiner must be notified at once	by Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	BLACK			
5-0036 led within 72 hours Hygiene. other than "natur	Completed b					
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	a	# HANSberry Moore MILDRED LEWIS				
MD 21 d 2 should Ith and Mer n 27 is man	욘	19a. Informant's Name/Relationship (Type, Print) MILDRED GARDNER (SISTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Milender Rd. White Marsh, MD 2				
					20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) CREMMOUNT CREMATORY ////////////////////////////////////	IORE, MD
Balti permit. Departn Import.	1	21 Signature of Funeral Source license 22. Name and Address of Facility VAUGHN GREENE FUN 4905 YORK Rd. BALTIMORE, MD.	1ERAL 3CVS 21212			
Physician Medical	0 2	23a. Part Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Approximate Interval Between Onset and Death			
£xaminer		or condition resulting in death) Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated (Disease or injury that initiated	,ra			
scuted and transit		I G				
760, cate be executed physician and the burial - trans	Medical	X UNPENDED AMENDED 23a,pt.II,27 per me g913 3-18-11 vt IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliv	rerv			
Box 687 e death certifice the attending ple ed for use as th	Physician/		Day Year			
P.O.	ğ	Chronic Obstructive Pulmonary Disease, Cirrhosis of 1 Yes 2 No 3 P				
of Vital Records, P.C of Physician: The law requires that ther this certificate has been signed to neral director, page 2 should be deta	Completed	Liver 24a. Was an autopsy performed? death 1 Yes 2 No 1				
cian: T	Be	25. Was case referred to medical 25.Place of Death (Check only one)				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Certification: To	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Voth 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 2 Ba. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 1 Yes 2 No	ner: Scene			
Division pital or Attendir ours after death. eral Director: A	Sertific	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or or Town, State)	Rural Route Number, City			
To the Hosy within 24 hd To the Fun completely i	edical		the cause(s)			
	≥	Morganite Me Ville O.C.M.E. January 8, 201				
8		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223				
St Regist	ate rar	TARE 1 12 GOOM TARE AND A STATE OF THE STATE				
DHMH 17 Rev 1/20	001	ORIGINAL 00	OME			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** George E. Miles Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Gardens Care Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day Ye July 20, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1947 **Funeral** M☐M 2☐F MD 63 212-48-2570 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23e or 28e-f show any injury or other freumetic event, the Medical Examents must be notified at once. Baltimore MD Middle River 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16 Taxi Way 21220 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify:White 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Fabricator Vulcan Hart 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George E. Miles Sr. Lillian Shoebrooke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sherri Kortum /daughter 7226 Gough Street Baltimore MD 21224 20b. Place of Disposition (Name of Data 20c. Location - City or Town, State 20a. Method of Disposition Gardens of Faith ₩ Burial 2 Cremation 3 Removal from State 1/13/11 Rossville MD 4 □ Dônation 5 □ Other (Specify) 22. Name and Address of Facility 21. Sign of Funeral Service Licensee 300 Mace Ave. Balto.MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ach Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be FSRD ND 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Tyes this 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation atural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0069314 1/10/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

11/12, Bearge

32. Registrar's Synature

Woot Rd MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chester G. Meyls :50AM Tan Medical 4c. County of Dogth 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Belair Health and Rehabilitation Center Belair Hartord 5. Social Security Number Ane (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth __(Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🔣 M 2 🗆 F 97 Hours Mary Land 213-07-6636 Director February 10,1913 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Directo Harford Maryland Joppa 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 235 Kilgore Court 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Horse Trainer Independent 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry C Meyls Sarah E. Holbrook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Kilgore Court, Joppa, Maryland 21085 19a. Informant's Name/Relationship (Type, Print)
Gail Coleman Niece 20a. Method of Disposition

1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cenetery 20c. Location - City or Town, State 1/13/2011 Finksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur- of Ameral Service Lig 22. Name and Address of Facility Burgee Henss-Seitz 3631 Falls Road, B Funeral Home, 21211 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, owneart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 22 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 2 Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B56545 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #106, BEL AIR, MD 45 W-MACPHAIL RD KHOSLA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 13 2011 Registrar

DHMH 17 Rev 7/2009